Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

South Carolina Department of Health and Human Services (SCDHHS)

Submission Date:	July 1, 2008

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
This request is for 5-year renewal of the South Carolina Home and Community Based Services Waiver for persons with Head and Spinal Cord Injury 0284.90.R1.

Application for a §1915(c) Home and Community-Based Services Waiver

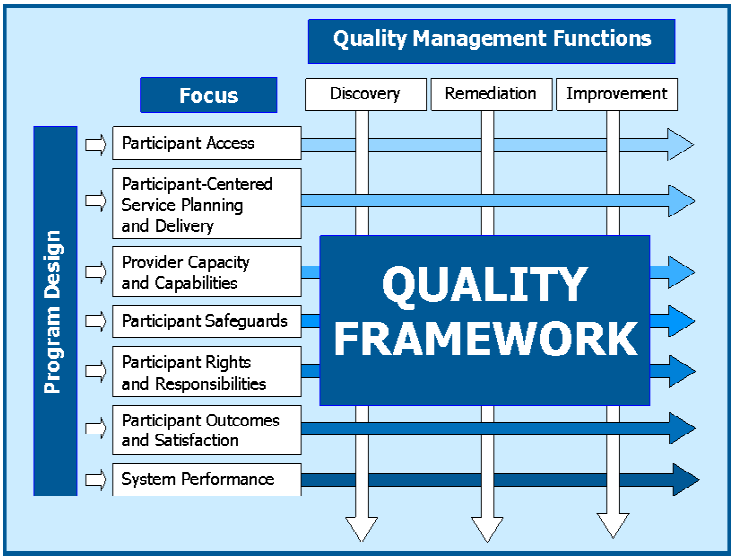
PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*



The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.

State:	South Carolina
Effective Date	7-1-2008

1. Request Information

A. The **State** of **South Carolina** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*): Head and Spinal Cord Injury (HASCI) Waiver

C. Type of Request *(select only one)*:

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
●	**Renewal (5 Years) of Waiver #**	0284.90.R1.	
○	**Amendment to Waiver #**		

D. Type of Waiver *(select only one)*:

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
●	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: 7/1/2008

E.2 Approved Effective Date *(CMS Use):*

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	○	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
■	Nursing Facility *(select applicable level of care)*	
	●	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
		Not Applicable
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
■	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	
	Not Applicable	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
■	Not applicable			

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

South Carolina is seeking to renew the *South Carolina Head and Spinal Cord Injury Waiver*. This Waiver will serve persons with traumatic brain injury, spinal cord injury or both or a similar disability not associated with the process of a progressive degenerative illness, disease, dementia or a neurological disorder related to the aging. All persons must meet either the Nursing Facility level of care or the ICF-MR level of care criteria.

Administrative authority for this Waiver is retained by the South Carolina Department of Health and Human Services (DHHS). The South Carolina Department of Disabilities and Special Needs (DDSN) perform Waiver operations under a memorandum of agreement and service contract with DHHS. DDSN has the operational responsibility for ensuring that participants are aware of their options under this Waiver. DDSN utilizes an organized health care delivery system that includes both county Disability and Special Need Boards and private providers as Waiver service providers. Services in this Waiver are provided at the local level mainly through a traditional service delivery system. This Waiver does have a participant-directed service that allows individuals or responsible party to direct their own attendant care services if they chose this option.

The services offered in this Waiver are meant to prevent and/or delay institutionalization in a nursing home or ICF/MR. This Waiver reflects the State's commitment to offer viable community options to institutional placement.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

●	The waiver provides for participant direction of services. *Appendix E is required.*
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. Appendix H contains the Quality Management Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

○	Yes
●	No
○	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
●	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

Meetings are held with stakeholders including consumers. Written notification is sent to Service Coordinators and Service Coordination Supervisors requesting information/input about any Waiver issues. MCAC meetings are coordinated by DHHS.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60

days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Jonathan
Last Name	Tapley
Title:	Program Coordinator II
Agency:	Department of Health and Human Services
Address 1:	PO Box 8206
Address 2:	
City	Columbia
State	South Carolina
Zip Code	29202
Telephone:	(803) 898-2702
E-mail	Tapley@SCDHHS.GOV
Fax Number	(803) 255-8209

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Linda
Last Name	Veldheer
Title:	Director, Head and Spinal Cord Injury Division
Agency:	Department of Disabilities and Special Needs
Address 1:	PO Box 4706
Address 2	Harden St. Ext.
City	Columbia
State	South Carolina
Zip Code	29240
Telephone:	(803) 898-9600
E-mail	LVeldheer@ddsn.sc.gov
Fax Number	(803) 898-9653

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Emma
Last Name	Forkner
Title:	Director
Agency:	Department of Health and Human Services
Address 1:	PO Box 8206
Address 2:	
City	Columbia
State	South Carolina
Zip Code	29202
Telephone:	(803) 898-2500
E-mail	Forkner@scdhhs.gov
Fax Number	(803) 898-4515

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not Applicable

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver *(select one)*:

○	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):
	○ The Medical Assistance Unit *(name of unit)*:
	○ Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)
●	The waiver is operated by **The Department of Disabilities and Special Needs** a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

A Memorandum of Agreement (MOA) between DHHS and DDSN is completed and reviewed every three (3) years. A service contract between DHHS and DDSN is completed and reviewed every three (3) years. The MOA and service contract ensure that the Waiver is operated by DDSN under the supervision of DHHS. DHHS exercises administrative discretion in the administration and supervision of the Waiver and issues policies, rules and regulations related to the HASCI Waiver. The MOA and service contract also set forth the formal communication schedule between the agencies. Bi-monthly operational level meetings are held between DHHS and DDSN. Quarterly policy level meetings are held between DHHS and DDSN with Deputy Directors and other administrative staff. Weekly/multiple contacts by telephone and email are conducted between DDSN and DHHS when necessary.

The MOA and service contract specify the entities performing the assurances of freedom of choice, level of care, quality assurance and issues of financial liability. DDSN reviews contracts and conducts Waiver program reviews with the Disabilities and Special Needs (DSN) Boards and other contracted providers annually. DDSN also amends contracts with DSN Boards and other contracted providers as necessary. DHHS will periodically conduct program reviews and review contracts to ensure full oversight of the DDSN quality assurance process.

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (s*elect one)*:

●	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	1. DHHS contracts with the USC School of Medicine: The School of Medicine currently performs quality assurance of the operational function of the University Affiliated Program (UAP) Attendant Care Program as an option of self-directed or designated responsible party-directed attendant care services. 2. DDSN contracts with the USC School of Medicine, Center for Disability Resources: This contract provides for the single point of preliminary intake and eligibility screening for all individuals seeking services through the Head and Spinal Cord Injury Division. 3. DDSN contracts with Delmarva Foundation: This contract between DDSN and Delmarva is for oversight and review of all Waiver services and providers participating in either the HASCI or MR/RD Waiver. 4. DHHS contracts with Qualis: This entity reviews ICF/MR levels of care preformed by DDSN. This entity provides monthly reports and quarterly summaries of the outcome of their review process.
○	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(check each that applies)*:

■	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
	1. DHHS contracts with DDSN for the operation of the Head and Spinal Cord Injury Waiver. 2. DDSN contracts with its local Disabilities and Special Needs (DSN) Board providers. Service coordination staff at the local Disabilities and Special Needs Board prepares the Plans of Service and complete reevaluations of NF and ICF/MR levels of care. 3. DDSN contracts with the Jasper Disabilities and Special Needs (DSN) Board which operates as the fiscal agent of the UAP Attendant Care Program.
●	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
	Private providers and other approved/qualified providers. Service coordination staff prepares the Support Plan and complete reevaluations for NF and ICF/MR levels of care.
☐	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Department of Health and Human Services and the Department of Disabilities and Special Needs jointly share the responsibility of assessing the performance of contracted local/regional non-state entities in conducting Waiver operational and administrative functions. The Jasper County Board of Disabilities and Special Needs (DSN) operates as the fiscal agent of the University Affiliated Project (UAP) Attendant Care Program. DDSN contracts with DSN Boards and other qualified/approved providers and the providers are assessed annually. Upon request, DHHS Medicaid Program Integrity Division also conducts reviews.

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Department of Health and Human Service (DHHS) and the Department of Disabilities and Special Needs (DDSN) jointly share responsibility in assessing the performance of contracted and local/regional non-state entities in conducting Waiver operational and administrative functions. DHHS

utilizes both a quality assurance contractor and its Medicaid Program Integrity (MPI) Division to oversee and review the operational functions of DDSN. The MOA sets forth both the operational agencies responsibility for quality assurance and the administering agencies oversight of the quality assurance process.

DDSN contracts with a private non-profit provider of quality assurance and quality performance to assess the local Disabilities and Special Needs Boards (DSN) and other qualified providers. DDSN also conducts reviews and provides technical assistance to the local Disabilities and Special Needs Boards and other contracted providers. DHHS completes quality assurance reviews of providers and submits findings to DDSN and DDSN reviews the findings with providers and provides technical assistance and follows up as necessary. DDSN Internal Audit Division conducts internal audit reviews of the local network of Disabilities and Special Needs Boards/other approved providers. The local Disabilities and Special Needs Boards and other contracted providers are required to have a financial audit conducted annually by a CPA firm chosen by the provider. DDSN Internal Audit Division also conducts special request audits, investigates fraud cases, provides training and technical assistance and reviews the audited financial statements of the local DSN Boards. DDSN Internal Audit Division conducts a review of the UAP (attendant care program) with the contracted fiscal agent.

DDSN's quality contractor assesses the local DSN Boards and other DDSN qualified/approved providers at least annually. The quality contractor also conducts follow-up reviews of the local DSN Boards and other approved providers. The quality contractor issues a comprehensive Report of Findings to the local DSN Board/provider and to DDSN. DDSN shares the Report of Findings with the administrative agency. The administrative agency reviews these reports and will conduct independent reviews to validate the findings of the DDSN quality contractor. Upon request, DHHS Medicaid Program Integrity (MPI) Division conducts reviews. Follow-up to the MPI reviews are conducted as necessary based on a Report of Findings. The quality contractor also completes annual mail-out surveys (family surveys) to supplement the quality review process. DDSN has been awarded a Choice Grant to evaluate the Quality Assurance process, specifically the Quality Framework

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	■	■	■	■
Assist individuals in waiver enrollment	■	■	■	■
Manage waiver enrollment against approved limits	■	■	■	■
Monitor waiver expenditures against approved levels	■	■	■	■
Conduct level of care evaluation activities	■	■	■	■
Review participant service plans to ensure that waiver requirements are met	■	■	■	■
Perform prior authorization of waiver services	☐	☐	■	■
Conduct utilization management functions	☐	■	■	■
Recruit providers	■	■	■	☐
Execute the Medicaid provider agreement	■	■	☐	☐
Determine waiver payment amounts or rates	■	☐	☐	☐
Conduct training and technical assistance concerning waiver requirements	■	■	■	■

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s)**. Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
●	**Aged or Disabled, or Both**			
☐	Aged (age 65 and older)			☐
■	Disabled (Physical)		65 for Waiver entry	
■	Disabled (Other)		65 for Waiver entry	
	Specific Aged/Disabled Subgroup			
■	Brain Injury		65 for Waiver entry	☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
☐	Developmental Disability			☐
☐	Mental Retardation			☐
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

b. **Additional Criteria**. The State further specifies its target group(s) as follows:

Participants on the HASCI Waiver before age 65 remain eligible for Waiver services after their 65th birthday if all other eligibility factors continue to be met. Waiver services are limited to participants with traumatic brain injury, spinal cord injury or both or a similar disability not associated with the process of a progressive, degenerative illness, disease, dementia, or a neurological disorder related to aging, regardless of the age of onset. Where the individual:

1. Has urgent circumstances affecting his/her health or functional status; and,
2. Is dependent on others to provide or assist with critical health needs, basic activities of daily living or requires daily monitoring or supervision in order to avoid institutionalization; and,
3. Needs services not otherwise available within existing community resources, including family, private means and other agencies/programs, or for whom current resources are inadequate to meet the basic needs of the individual, which would allow them to remain in the community.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

○	Not applicable – There is no maximum age limit
●	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):
	Participants on the HASCI Waiver before age 65 remain eligible for Waiver services after their 65th birthday if all other eligibility factors continue to be met.

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

- ● **No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.
- ○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*. The limit specified by the State is *(select one)*:
  - ○ _____ %, a level higher than 100% of the institutional average
  - ○ Other *(specify)*:
- ○ **Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.
- ○ **Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c*.

  The cost limit specified by the State is *(select one)*:
  - ○ The following dollar amount: $ _____
    The dollar amount *(select one)*:
    - ○ Is adjusted each year that the waiver is in effect by applying the following formula:
    - ○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
  - ○ The following percentage that is less than 100% of the institutional average: _____ %
  - ○ Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	788
Year 2	842
Year 3	892
Year 4 (renewal only)	945
Year 5 (renewal only)	998

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

○	The State does not limit the number of participants that it serves at any point in time during a waiver year.
●	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	750
Year 2	800
Year 3	850
Year 4 (renewal only)	900
Year 5 (renewal only)	950

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

●	**Not applicable**. The state does not reserve capacity.
○	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

●	The waiver is not subject to a phase-in or a phase-out schedule.
○	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

●	Waiver capacity is allocated/managed on a statewide basis.
○	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

This Waiver maintains two waiting lists based on level of need: an Urgent and a Regular waiting list. The criteria for the Urgent waiting list are:

1. Very severe injury with functional limitations a spinal cord injury at the quadriplegic level or extremely or severe head injury.
2. Emergency need for assistance with personal care.
3. The recent loss (permanently gone within the past 90 days) or imminent risk of losing a primary caregiver (permanently gone within the next 90 days), and no other natural supports to replace the primary caregiver.
4. Recently discharged (within the past 90 days) or pending discharge (within the next 90 days) from acute care or rehabilitation hospital with complex unmet service needs
5. Lack of active support network

Participants must have at least two of the above criteria in order to meet the requirements for inclusion on the Urgent waiting list. Participants who meet Urgent criteria will be allocated the first available HASCI Waiver slot. If more than one individual is on the Urgent waiting list, they will be allocated an available HASCI Waiver slot based on the earliest date of request. Individuals on the Regular waiting list will be allocated an available HASCI Waiver slot based on earliest date of request if there are no current applicants on the Urgent waiting list.

An individual terminated from the Waiver because of hospitalization or temporary admission to a nursing facility exceeding a full calendar month will have his or her Waiver slot held up to 90 calendar days if it is anticipated the individual will be discharged during that time. Re-enrollment in the Waiver is contingent upon the individual continuing to meet all eligibility requirements.

An individual terminated from the Waiver due to the interruption of Medicaid eligibility for more than 30 days but less than 90 calendar days will have his/her slot held up to 90 days for Medicaid eligibility to be reinstated.

An individual who has not received a Waiver service for 30 calendar days due to non-availability of a provider will have his or her slot held up to 90 calendar days. If a provider is located within 90 calendar days, the individual will be re-enrolled into the HASCI Waiver as long as all other eligibility criteria are met.

An individual who has resided in a nursing facility, hospital swing bed, or administrative day bed for 90 days or more and who requests to be discharged to receive community based services will immediately be allocated a Waiver slot after medical, financial and other Waiver eligibility requirements are met. Transition must be arranged through a DDSN Service Coordinator.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

●	§1634 State
○	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)				
■	Low income families with children as provided in §1931 of the Act			
■	SSI recipients			
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121			
☐	Optional State supplement recipients			
■	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*			
	●	100% of the Federal poverty level (FPL)		
	○	%	of FPL, which is lower than 100% of FPL	
■	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)			
■	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)			
☐	Medically needy			
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*				
○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.			
●	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5*.			
	○	All individuals in the special home and community-based waiver group under 42 CFR §435.217		

	●	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:			
	■	A special income level equal to (select one):			
		●	300% of the SSI Federal Benefit Rate (FBR)		
		○	%	of FBR, which is lower than 300% (42 CFR §435.236)	
		○	$	which is lower than 300%	
	☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)			
	☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)			
	☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)			
	■	Aged and disabled individuals who have income at: *(select one)*			
		●	100% of FPL		
		○	%	of FPL, which is lower than 100%	
	☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

●	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
	● Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
	○ Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	●	The special income level for institutionalized persons *(select one):*		
		●	300% of the SSI Federal Benefit Rate (FBR)	
		○ %	of the FBR, which is less than 300%	
		○ $	which is less than 300%.	
	○	%	of the Federal poverty level	
	○	Other (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	

○	The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:		If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

iii. Allowance for the family *(select one)*:

●	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		
○	Not applicable (see instructions)		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
●	The State establishes the following reasonable limits *(specify)*:

1. Prescription drugs above the four (4) prescriptions-per-month limit, not to exceed $54.00 per additional prescription per month.
2. Eyeglasses not otherwise covered by the Medicaid program, not to exceed a total of $108 per occurrence for lenses, frames and dispensing fee. A licensed optometrist or opthamologist must certify the necessity of eyeglasses.
3. Dentures. A one-time expense not to exceed $651.00 per plate or $1320.00 for one full pair of dentures. A licensed dental practitioner must certify necessity. An expense for more than one pair of dentures must be prior approved by State DHHS.
4. Denture repair. Justified as necessary by a licensed dental practitioner. Not to exceed $69 per visit.
5. Physician and other medical practitioner visits that exceed the yearly limit, not to exceed $69 per visit.
6. Hearing Aids. A one-time expense. Not to exceed $1000.00 for one or $2000.00 for both. Necessity must be certified by a licensed practitioner. An expense for more than one hearing aid must be prior approved by State DHHS.
7. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % of the FBR, which is less than 300%
    - ○ $ which is less than 300% of the FBR
  - ○ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The following standard under 42 CFR §435.121
- ○ Optional State supplement standard
- ○ Medically needy income standard
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The amount is determined using the following formula:
- ○ Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

- ○ AFDC need standard
- ○ Medically needy income standard

○	The following dollar amount: $ [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ ____ % of the FBR, which is less than 300%
    - ○ $ ____ which is less than 300%.
  - ○ ____ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

  Specify the amount of the allowance:
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
  - ○ The amount is determined using the following formula:
- ● Not applicable

iii. Allowance for the family *(select one)*:	
○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other (specify):		

○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		

ii. Allowance for the spouse only (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:			
	Specify the amount of the allowance:			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:		
○	Not applicable			

iii. Allowance for the family *(select one)*

○	AFDC need standard	
○	Medically needy income standard	
○	The following dollar amount: $	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:	
○	Other (specify):	
○	Not applicable (see instructions)	

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third

party, specified in 42 CFR 435.735:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**	
○	SSI Standard
○	Optional State Supplement standard
○	Medically Needy Income Standard
●	The special income level for institutionalized persons
○	_____ of the Federal Poverty Level
○	The following dollar amount: _____ If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:
○	Other (*specify*)**:**
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*	
●	Allowance is the same
○	Allowance is different. Explanation of difference:
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:	
a. Health insurance premiums, deductibles and co-insurance charges. b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
○	The State does not establish reasonable limits.
●	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):*	
	1	
ii.	**Frequency of services**. The State requires *(select one)*:	
	●	The provision of waiver services at least monthly
	○	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	Directly by the Medicaid agency
○	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
●	Other (*specify*):
	This Waiver employs both the Nursing Facility and ICF/MR levels of care in assessing potential Waiver eligibility. The majority of the participants currently enrolled in this Waiver are assessed using the Nursing Facility level of care. The initial Nursing Facility level of care evaluation is performed directly by the Medicaid agency. All reevaluations of the Nursing Facility level of care are done by service coordinators employed by contracted providers of the operating agency. All initial ICF/MR level of care evaluations are preformed directly by the operating agency, reevaluations of the ICF/MR level of care are preformed by service coordinators employed by contracted providers of the operating agency.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Registered Nurse licensed by the State or Licensed Practical Nurse working under the auspices of a Registered Nurse. Physician (M.D. or D.O.) and the DDSN Director of Consumer Assessment.

DDSN Director of Consumer Assessments: Minimum qualifications are a Master's degree in Social Work or a related field from an accredited college or university; or a Bachelor's degree in Social Work from an accredited college or university; or a Bachelor's degree from an accredited college or university in an unrelated field of study, and at least one year of experience in programs for persons with mental retardation or a service coordination program. Psychologist: Minimum qualifications are a Master's degree in psychology plus two years of experience working with persons with lifelong disabilities, or a Master's degree in a health or human service field plus four years experience working with person with lifelong disabilities.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

A standardized instrument is utilized to gather assessment information necessary for level of care determinations.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

●	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
○	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The same process is used. The same level of care instrument and process are used.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○	Every three months
○	Every six months
●	Every twelve months
○	Other schedule (*specify*):

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

○	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
●	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:
	Service Coordinators must hold a Master's or Bachelor's degree in Social Work or a related field or a Bachelor's degree in an unrelated field of study and have one (1) year of experience working with individuals with head and spinal cord injury or related disabilities, or in a case management program.

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

An automated tickler system produced by the Medicaid agency tracks due dates and timing of reevaluations if the Medicaid agency has not received level of care determinations in a timely manner inquires and requests are sent for the outstanding level of cares. Additionally if any level of care is found out of date FFP is taken back from the operating agency for any services that were billed when the level of care was not timely.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Original documents are housed with the contracted providers of the operating agency. Copies of the records are housed with the Medicaid Agency.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Long-term care options are discussed with potentially eligible individuals (or their legal representatives) during the assessment and subsequent visits.

A written Freedom of Choice Form (Service Choice Form) is secured from each Waiver participant to ensure that the participant is involved in planning his/her long-term care. This choice will remain in effect until the participant changes his/her mind. If the participant lacks the physical or mental ability required to make a written choice regarding his/her care, a responsible party may sign the Freedom of Choice Form.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Participant Service Choice Forms are maintained for a minimum three years with the contracted providers of the operating agency. The Freedom of Choice Form is maintained in the participant's record.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The operating agency requires that each provider agency be in compliance with Tile VI and establish a grievance procedure to assure that everyone is given a fair and timely review of all complaints alleging discrimination. All contracts through the operating agency with provider agencies will contain an "Assurance of Compliance" statement. Compliance Coordinators within the provider agencies will be responsible for assuring compliance and access to services by persons with limited English proficiency. The Compliance Coordinator is responsible for maintaining records documenting the complaints filed and actions that are taken to bring resolution to the complaint(s). A State Compliance Coordinator will be responsible for monitoring the compliance process. The State Coordinator will assist the provider agency Compliance Coordinator with identifying resources when necessary. The State Compliance Coordinator will notify the administrative agency of any discrimination complaints that have been filed.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	■	Attendant Care/Personal Assistance Services
Adult Day Health	☐	
Habilitation	☐	
Residential Habilitation	■	
Day Habilitation	■	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	■	
Supported Employment	■	
Education	■	
Respite	■	Respite Care
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
●	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Environmental Modifications
b.	Medical Supplies, Equipment and Assistive Technology

c.	Medicaid Waiver Nursing
d.	Personal Emergency Response Systems
e.	Psychological Services
f.	Behavioral Support Services
g.	Private Vehicle Modifications
h.	Health Education for Consumer-Directed Care
i.	Peer Guidance for Consumer-Directed Care

Extended State Plan Services *(select one)*

○	Not applicable
●	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	Physical Therapy Services
b.	Occupational Therapy Services
c.	Speech, Hearing and Language Services
d.	Prescribed Drugs, except drugs furnished to participants who are eligible for Medicare Part D benefits

Supports for Participant Direction *(select one)*

●	The Waiver provides for participant direction of services as specified in Appendix E. Indicate whether the Waiver includes the following supports or other supports for participant direction.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	■	
Financial Management Services	■	

Other Supports for Participant Direction *(list each support by service title)*:

a.	
b.	
c.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

■	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c*.
☐	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Service Coordination is provided by the Department of Disabilities and Special Needs (DDSN) through contracts with:

1. The local Disabilities and Special Needs (DSN) Board providers.
2. Private providers and other approved/qualified providers.

Service Coordination staff prepares and monitor implementation of the Support Plan, assess service needs, facilitate initial Waiver enrollment, complete reevaluations for NF and ICF/MR levels of care, and monitor the health and welfare of the participants in the Head and Spinal Cord Injury Waiver.

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-*(select one)*:

●	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., attendants/personal assistants, personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	Community Residential Care Facilities, Home Health Agencies, Adult Day Health Care agencies, Personal Care Agencies and Attendants and DDSN are all required to have background checks done on direct care staff. These are state level investigations performed by South Carolina Law Enforcement (SLED checks) for each of the agencies above that hire and recruit direct care staff. The State Health Department performs licensure inspections on CRCF and Home Health agencies. DDSN performs licensure inspections on its facilities. DDSN also conducts quality reviews of HASCI Waiver requirements. Background checks are required for attendants providing attendant care/personal assistance services. DHHS reviews agency and independently enrolled attendant care/personal assistance providers to ensure background checks have been performed on direct care staff. DDSN contracts with a provider of quality assurance and quality performance that conducts reviews of local Disabilities and Special Needs Boards at least annually. The quality contractor reviews a percentage of the personnel records of direct support staff (attendant care/personal assistance services staff) to determine if the minimum requirements for employment were met. The findings from the administrative reviews are shared with DDSN and with the State (DHHS).
○	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

○	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
●	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*

●	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*.

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
CRCF (DDSN contracted)	Residential Habilitation	N/A
CTH I	Residential Habilitation	2
CTH II	Residential Habilitation	4
SLP I	Residential Habilitation	3
SLP II	Residential Habilitation	3

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The individual is able to access community services on an on-going basis to increase his/her independence. The Waiver can provide supplemental services for persons that require more care and assistance than what is provided in that setting. Waiver services must comply with any licensing requirements of that setting.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type CRCF	Facility Type CTH I	Facility Type CTH II	Facility Type SLP I and SLP II
Admission policies	■	■	■	■
Physical environment	■	■	■	■
Sanitation	■	■	■	■
Safety	■	■	■	■
Staff : resident ratios	■	■	■	■
Staff training and qualifications	■	■	■	■
Staff supervision	■	■	■	■
Resident rights	■	■	■	■
Medication administration	■	■	■	■
Use of restrictive interventions	■	■	■	■
Incident reporting	■	■	■	■
Provision of or arrangement for necessary health services	■	■	■	■

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

●	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians**. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
○	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
○	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
●	Other policy. *Specify*:

	Reimbursement for HASCI Waiver services may be made to certain family members who meet South Carolina Medicaid provider qualifications. The following family members may not be reimbursed: the spouse of a Medicaid participant; a parent of a minor Medicaid participant; a step-parent of a minor Medicaid participant; a foster parent of a minor Medicaid participant; any other person legally responsible (sole, joint or otherwise) for the Medicaid participant; and a court appointed guardian of a Medicaid participant. A family member that is a primary caregiver will not be reimbursed for Respite Care services. All other qualified family members may be reimbursed for their provision of the services listed above. Should there be any question as to whether a paid caregiver falls in any of the categories listed above, SCDHHS legal counsel will make a determination.

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Potential providers are given the opportunity to enroll/contract with the South Carolina Medicaid and/or subcontract with DDSN. Potential providers are made aware of the requirements for enrollment through either the operating or administrating agency by contacting them directly. Potential providers are given a packet of information that is used in the enrollment and/or subcontracting process. DDSN/DHHS will validate the provider meets all standards and qualifications and then the Medicaid agency may enroll the provider should they choose to enroll with the Medicaid agency.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Attendant Care/Personal Assistance Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
●	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Attendant Care/Personal Assistance Services are supports for personal care and activities of daily living specific to the assessed needs of a medically stable individual with physical and/or cognitive impairments. Supports may include direct care, hands-on assistance, direction and/or cueing, supervision, and nursing to the extent permitted by State law. Supports may be provided in the participant's home and/or a variety of community settings as indicated in the Support Plan, but only when attendant care/personal assistance is not already available in such settings. Housekeeping activities incidental to care or essential to the health and welfare of the participant, rather than the participant's family, may be provided as specified in the Support Plan. Supports provided during community access activities must directly relate to the participant's needs for care and/or supervision. Transportation may be provided as a component of Attendant Care/Personal Assistance Services when necessary for provision of personal care or performance of daily living activities. Cost of incidental transportation is included in the rate paid to providers.

Supervision will be provided by a nurse licensed to practice in the state. The frequency and intensity of the supervision will be specified in the participant's Support Plan.

As an option, supervision may be performed directly by the participant or a responsible party, when the participant or responsible party has been trained to perform this function, and when safety and efficacy of supervision provided by the participant or responsible party has been certified by a licensed nurse or otherwise as provided in State law. Certification must be based on direct observation of the participant or responsible party and the specific attendant care/personal assistance provider(s) during actual provision of care. Documentation of this certification will be maintained in the participant's Support Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Attendant Care/Personal Assistance Services provided on a routine basis shall be limited to 8 hours per day.

Up to 10 hours per day may be authorized on a short-term basis (not to exceed 90 days) due to special need circumstances such as the participant's temporary injury or illness, temporary absence or illness of a primary caregiver, etc. If Attendant Care/Personal Assistance Services is combined with HASCI Waiver Nursing Services, the combined services, whether routine or short term, shall not exceed 12 hours per day.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Independent attendant care providers		Attendant care provider agencies	

			DSN Boards/contracted providers		
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	■	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Attendant care provider agencies			Contract scope of services
DSN Board/contracted providers			DDSN Home Supports Caregiver Policy, Pre-service Training Requirements and Orientation (567-01-DD) which lists requirements to include the outline of minimum requirements for the curriculum for HASCI Waiver caregivers
Independent attendant care providers			Contract Scope of Service/DDSN Home Supports Caregiver Policy, Pre-service Training Requirements and Orientation (567-01-DD) which lists requirements to include the outline of minimum requirements for the curriculum for HASCI Waiver caregivers

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	Attendant care provider agencies	Medicaid agency	Annually/biannually
	DSN Board/contracted providers	Department of Disabilities and Special Needs/Medicaid Agency	Upon enrollment or service authorization
	Independent attendant care providers	Licensed nurse under a contract with state Medicaid agency	Upon enrollment; annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Residential Habilitation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Residential Habilitation means personal care, assistance with activities of daily living, supervision, behavioral supports, and skills training provided in a licensed residential program or unlicensed setting. Individually tailored supports and training assist the participant to reside in the most integrated setting appropriate to his or her needs. Supports may include direct care, hands-on assistance, direction and/or cueing, supervision, and nursing to the extent permitted by State law. Training is focused on the acquisition, retention, or improvement in skills for living in the community with maximum independence. Supports may include social and leisure activities and community inclusion opportunities.

Payment for Residential Habilitation does not include the cost of room and board or building maintenance, upkeep and improvement, other than such costs for modifications or adaptations required to assure the health and safety of residents, or to meet requirements of the applicable life safety code. Payment for Residential Habilitation will not be made, directly or indirectly, to members of the participant's immediate family. Payment will not be made for the routine care and supervision expected to be provided by a family or residential provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications		
Provider Category(s) *(check one or both)***:**	■ Individual. List types:	■ Agency. List the types of agencies:
	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)	DSN Board/contracted providers
		Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
		Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DSN Board/contracted	Yes, Section 44-20-10 et. Seq.,		Contracted with Department of Disabilities and Special Needs

providers	Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103		
In unlicensed settings: Rehabilitation programs		Certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF).	Contracted with Department of Disabilities and Special Needs
In unlicensed settings: Certified Rehabilitation Counselors (Individuals and Agencies)		Certified by the Commission on Rehabilitation Counselor Certification (CRCC).	Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DSN Board/contracted providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	In unlicensed settings: Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF).	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	In unlicensed settings: Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies)	Department of Disabilities and Special Needs	Upon enrollment or service authorization

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Day Habilitation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

O	Service is included in current waiver. There is no change in service specifications.
●	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Day Habilitation is assistance with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the participant resides. Services shall normally be provided four (4) or more hours per day on a regularly scheduled basis for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's Support Plan.

Day Habilitation services shall focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the Support Plan. In addition, Day Habilitation services may reinforce skills taught in school, therapy or other settings.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	■ Individual. List types:	■ Agency. List the types of agencies:
	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)	DSN Board/contracted providers
		Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
		Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DSN Board/contracted	Yes, Section 44-20-10 et. Seq.,		Contracted with Department of Disabilities and Special Needs

provider	Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103		
In unlicensed settings: Rehabilitation programs		Certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)	Contracted with Department of Disabilities and Special Needs
In unlicensed settings: Certified Rehabilitation Counselors (Individuals and Agencies)		Certified by the Commission on Rehabilitation Counselor Certification (CRCC)	Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DSN Board/contracted providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	In unlicensed settings: Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	In unlicensed settings: Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies)	Department of Disabilities and Special Needs	Upon enrollment or service authorization

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Prevocational Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
●	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

When compensated, individuals are paid less than 50 percent of the minimum wage. Activities include in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of service as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)		DSN Board/contracted providers
				Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
				Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DSN Board/contracted providers	Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103		Contracted with Department of Disabilities and Special Needs
In unlicensed settings: Rehabilitation programs		Certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)	Contracted with Department of Disabilities and Special Needs
In unlicensed settings: Certified Rehabilitation Counselors (Individuals and Agencies)		Certified by the Commission on Rehabilitation Counselor Certification (CRCC)	Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DSN Board/contracted providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	In unlicensed settings: Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	In unlicensed settings: Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies)	Department of Disabilities and Special Needs	Upon enrollment or service authorization

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Supported Employment

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
●	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Supported Employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported Employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by individuals receiving Waiver services, including supervision and training. When Supported Employment services are provided at the work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported Employment services furnished under the Waiver are not available under a program funded by the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation may be provided between the participant's residence and the site of habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider	☐	Individual. List types:	■	Agency. List the types of agencies:

Category(s) *(check one or both)*:	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)	DSN Board/contracted providers
		Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
		Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DSN Board/contracted providers	Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103		Contracted with Department of Disabilities and Special Needs
In unlicensed settings: Rehabilitation programs		Certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)	Contracted with Department of Disabilities and Special Needs
In unlicensed settings: Certified Rehabilitation Counselors (Individuals and Agencies)		Certified by the Commission on Rehabilitation Counselor Certification (CRCC)	Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DSN Board/contracted providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization

	In unlicensed settings: Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	In unlicensed settings: Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies)	Department of Disabilities and Special Needs	Upon enrollment or service authorization

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Respite Care Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
●	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Personal care and supervision provided to individuals unable to care for themselves. Respite Care is provided on a short-term basis because of the absence of or need for relief of regular unpaid caregivers. Respite Care services are provided in a variety of settings and may be provided on an hourly or daily basis. FFP will not be claimed for the cost of room and board except when provided as part of Respite Care provided in a facility approved by the State that is not a private residence.

Respite Care may be provided in the following locations:

- Individual's home or other private residence selected by the consumer/representative.
- Group home (may be defined as a DDSN residential facility, DSS foster care facility or CRCF)
- Foster home
- Medicaid certified hospital
- Medicaid certified nursing facility
- Medicaid certified ICF/MR
- Licensed Community Residential Care Facility (CRCF)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Nursing Facility
				Hospital
				Licensed Community Residential Care Facility
				DSN Board/contracted providers
				Foster Home
				Medicaid certified ICF/MR
				Respite provider agencies
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Nursing Facility	Yes, SC Code, Sec. 44-7-250		

	Reg. #61-17, Equivalent for NC & GA		
Hospital	Yes, SC Code, Sec. 44-7-260 Reg. #61-16, Equivalent for NC & GA		
Licensed Community Residential Care Facility	Yes, SC Code, Sec. 44-7-260 Reg. #61-84, Equivalent for NC & GA		
Medicaid certified ICF/MR	Yes, SC Code, Sec. 44-7-250 Reg. #61-17		Respite care standards policy, Contract Scope of Service/DDSN Home Supports Caregiver Policy, Pre-service Training Requirements and Orientation (567-01-DD) which lists requirements to include the outline of minimum requirements for the curriculum for HASCI Waiver caregivers
DSN Board/contracted providers	Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103		Contracted with Department of Disabilities and Special Needs/Respite care standards policy, Pre-service Training Requirements and Orientation (567-01-DD) which lists requirements to include the outline of minimum requirements for the curriculum for HASCI Waiver caregivers
Foster Home	Yes, SC Code, Sec. 20-7-2250		
Respite provider agencies			MOA and Service Contract with Department of Health and Human Services

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Nursing Home	Medicaid Agency, Department of Health and Environmental Control	Upon Enrollment; Annually
	Hospitals	Medicaid Agency, Department of Health and Environmental Control	Upon Enrollment; Annually
	Residential Care Facilities	Medicaid Agency, Department of Health and Environmental Control	Upon Enrollment; Annually

	Foster Home	Department of Social Services	Upon Enrollment; Annually
	Medicaid Certified ICF/MR facility	Department of Health and Environmental Control	Upon Enrollment Annually
	Local DSN Board/contracted providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	Respite provider agencies	Medicaid Agency	Upon Enrollment Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Environmental Modifications

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Those physical adaptations to the home, required by the individual's Support Plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home. The home must be a privately owned residence occupied by the participant. Modifications to publicly funded group homes or community residential facilities are not permitted. Such adaptations may include the installation of ramps and grab-bars, widening of doorways and automatic door systems, modification of bathroom or kitchen facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual, floor covering to facilitate wheelchair access, fencing necessary for a participant's safety. Environmental modifications may also include consultation and assessments to determine the specific needs and follow-up inspections upon completion of the project.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Environmental modifications will not be approved solely for the needs or convenience of other occupants of the home or care providers. Modifications that add to the total square footage of the home are available only when this modification proves to be the most cost effective solution. All services shall be provided in accordance with applicable state and local building codes and shall be subject to the state procurement act.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Environmental Modifications are subject to the guidelines established by DDSN and must be within a limit of $20,000 dollars per request.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Licensed Occupational and Physical Therapists		DSN Boards/contracted providers	
	Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)		Durable Medicaid Equipment Providers	
	Environmental Access Consultants/contractors certified		Occupational and Physical Therapy Agencies	

	Consultants/contractors certified by Professional Resources in Management (PRIME).	
	Licensed Contractors	Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)
	Technicians or professionals certified in the installation and repair of manufacturers equipment	Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME).
		Licensed Contractors
		Vendors with a retail or wholesale business license contracted to provide services
		Technicians or professionals certified in the installation and repair of manufacturers equipment

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Contractor (Individuals and Agencies)	Code of laws, 1976 as amended 40-59-15 et seq.		Contracted with Department of Disabilities and Special Needs/Medicaid Agency
DSN Board/contracted providers	Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103		Contracted with Department of Disabilities and Special Needs
Durable Medicaid Equipment Providers	Yes, Section 33-1-200 et. Seq. thru 33-1-420		Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Licensed Occupational and Physical Therapists (Individuals and Agencies)	Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC		Contracted with Department of Disabilities and Special Needs/Medicaid Agency

	and GA. Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.		
Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers (Individuals and Agencies)		Certified by the Rehabilitation Engineering Society of North America (RESNA)	Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Environmental Access Consultants/contractors (Individuals and Agencies)		Certified by Professional Resources in Management (PRIME)	Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Licensed contractors (Individuals and Agencies)	Yes, Section 33-1-200 et. Seq. thru 33-1-420		Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Vendors with a retail or wholesale business license contracted to provide services (Individuals and Agencies)	Yes, Section 33-1-200 et. Seq. thru 33-1-420		Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Technicians or professionals certified in the installation and repair of manufacturers equipment (Individuals and Agencies)	Yes, Section 33-1-200 et. Seq. thru 33-1-420		Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Licensed Contractor (Individuals and Agencies)	Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or Medicaid enrollment
	DSN Board/contracted providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization

	Durable Medicaid Equipment Providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization and/ or Medicaid enrollment
	Licensed Occupational and Physical Therapists (Individuals and Agencies)	Department of Disabilities and Special Needs	Upon enrollment or service authorization and/ or Medicaid enrollment
	Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA) (Individuals and Agencies)	Department of Disabilities and Special Needs	Upon enrollment or service authorization and/ or Medicaid enrollment
	Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME). (Individuals and Agencies)	Department of Disabilities and Special Needs	Upon enrollment or service authorization and/ or Medicaid enrollment
	Vendors with a retail or wholesale business license contracted to provide services (Individuals and Agencies)	Department of Disabilities and Special Needs	Upon enrollment or service authorization and/ or Medicaid enrollment
	Technicians or professionals certified in the installation and repair of manufacturers equipment (Individuals and Agencies)	Department of Disabilities and Special Needs	Upon enrollment or service authorization and/ or Medicaid enrollment

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Medical Supplies, Equipment and Assistive Technology
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Specialized medical supplies and equipment to include devices, controls, or appliances specified in the participant's Support Plan which enable increased ability to perform activities of daily living, or to perceive, control, or communicate with the environment.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the state plan or which are not available under the state plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacturer, design and installation. Cost of items may include consultation and assessments to determine the specific needs, follow-up inspection after items are received, training in use of equipment/assistive technology, repairs not covered by warranty, and replacement of parts or equipment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Independent Rehabilitation Engineering Technologists, assistive technology practitioners, and assistive technology suppliers certified by the Rehabilitation Engineering Society of North America. (RESNA)		DSN Board/contracted providers	
	Independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)		Durable Medical Equipment providers	
	Licensed Occupational or Physical Therapists		Licensed Occupational or Physical Therapy Agencies	

	Vendors with a retail or wholesale business license	Independent Rehabilitation Engineering Technologists, assistive technology practitioners, and assistive technology suppliers certified by the Rehabilitation Engineering Society of North America. (RESNA)
	Technicians or professionals certified in the installation and repair of manufacturer's equipment	Independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)
		Vendors with a retail or wholesale business license
		Technicians or professionals certified in the installation and repair of manufacturer's equipment

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Durable Medical Equipment providers	Yes, Section 33-1-200 et. Seq. thru 33-1-420		Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Independent Rehabilitation Engineering Technologists, assistive technology practitioners, and assistive technology suppliers (Individuals and Agencies)		Certified by the Rehabilitation Engineering Society of North America (RESNA).	Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Independent Environmental Access Consultants/contractors (Individuals and Agencies)		Certified by Professional Resources in Management (PRIME)	Contracted with Department of Disabilities and Special Needs/Medicaid Agency
DSN Board/contracted providers	Yes, Section 44-20-10 et. Seq.,		Contracted with Department of Disabilities and Special Needs

	Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103		
Licensed Occupational or Physical Therapists (Individuals and Agencies)	Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA. Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.		Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Vendors with a retail or wholesale business license (Individuals and Agencies)	Yes, Section 33-1-200 et. Seq. thru 33-1-420		Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Technicians or professionals certified in the installation and repair of manufacturer's equipment (Individuals and Agencies)	Yes, Section 33-1-200 et. Seq. thru 33-1-420		Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Durable Medical Equipment providers	Medicaid Agency or Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or Medicaid enrollment
	Independent Rehabilitation Engineering Technologists, assistive technology practitioners, and assistive technology suppliers certified by the Rehabilitation Engineering Society of North America. (Individuals and Agencies)	Medicaid Agency or Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or Medicaid enrollment

	Independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME) (Individuals and Agencies)	Medicaid Agency or Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or Medicaid enrollment
	DSN Board/contracted providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	Licensed Occupational or Physical Therapists (Individuals and Agencies)	Department of Disabilities and Special Needs and/or Medicaid Agency	Upon enrollment or service authorization and/or enrollment with Medicaid Agency
	Vendors with a retail or wholesale business license (Individuals and Agencies)	Department of Disabilities and Special Needs and/or Medicaid Agency	Upon enrollment or service authorization and/or enrollment with Medicaid Agency
	Technicians or professionals certified in the installation and repair of manufacturer's equipment (Individuals and Agencies)	Department of Disabilities and Special Needs and/or Medicaid Agency	Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Service Delivery Method				
	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Medicaid Waiver Nursing

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Services specified in the plan of service which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Nursing services are limited to 60 hours of LPN services per week and 44 hours of RN services per week.

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Individual Nurses		Nursing Agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Nurses (Individuals and Agencies)	Yes, Code of laws 40-33-10 et seq		Contract Scope of services

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Nurses (Individuals and Agencies**)**	Medicaid Agency	Upon Enrollment Annually/Biannually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Personal Emergency Response Systems

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

PERS is an electronic device which enables individuals at high risk of institutionalization to secure help in an emergency. The participant may wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for any part of the day or night, and who would otherwise require extensive routine supervision.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				DSN Boards/contracted providers
				Personal Emergency Response providers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DSN Boards/contracted providers			1. FCC Part 68 2. UL (Underwriters Laboratories) approved as a "health care signaling product." 3. The product is registered with the FDA as a medical device under the classification "powered environments control signaling product."
Personal Emergency Response providers			1. FCC Part 68 2. UL (Underwriters Laboratories) approved as a "health care signaling product." 3. The product is registered with

			the FDA as a medical device under the classification "powered environments control signaling product."

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DSN Boards/contracted providers	Department of Disabilities of and Special Needs	Upon enrollment or service authorization
	Personal Emergency Response providers	Medicaid Agency	Upon enrollment

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Psychological Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Psychological services address affective, cognitive, and substance abuse problems of an individual. Psychological services include psychiatric, neuropsychological, and psychological assessment and testing; development of treatment plans; individual/client specific family counseling regarding emotions, behavior or social interaction; cognitive rehabilitation therapy; alcohol/substance abuse counseling; and consultation with family members, friends and service providers to assist the participant with affective, cognitive and substance abuse problems.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)		DSN Boards/contracted providers
		Psychological service providers approved by SCDDSN/SCDHHS		Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)
				Psychological service providers approved by SCDDSN/SCDHHS
				Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DSN Boards/contracted providers			Scope of Service verified by DDSN and approved by DHHS

Rehabilitation programs		Certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)	Scope of Service verified by DDSN and approved by DHHS
Psychological service providers approved by SCDDSN/SCDHHS (Individuals and Agencies)			Scope of Service verified by DDSN and approved by DHHS
Certified Rehabilitation Counselors (Individuals and Agencies)		Certified by the Commission on Rehabilitation Counselor Certification (CRCC)	Scope of Service verified by DDSN and approved by DHHS

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)	Medicaid agency/South Carolina Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or enrollment with Medicaid Agency
	Psychological service providers approved by SCDDSN/SCDHHS (Individuals and Agencies)	Medicaid agency/South Carolina Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or enrollment with Medicaid Agency
	DSN Boards/contracted providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization

	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies)	Medicaid agency/South Carolina Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Behavioral Support Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Behavioral support services address problem behaviors of an individual by using validated practices to identify causes and appropriate interventions that prevent or reduce occurrence. Behavioral support services include functional behavior assessments and analyses; development of behavioral support plans; implementing interventions designated in behavioral support plans; training key persons to implement interventions designated in behavioral support plans; monitoring effectiveness of behavioral support plans and modifying as necessary; and educating family, friends, or service providers concerning strategies and techniques to assist the participant in controlling/modifying inappropriate behaviors.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)		DSN Boards/contracted providers
		Behavior Support providers approved by SCDDSN/SCDHHS		Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)
				Behavior Support providers approved by SCDDSN/SCDHHS
				Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DSN Boards/contracted providers			Scope of Service verified by DDSN and approved by DHHS

Rehabilitation programs		Certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)	Scope of Service verified by DDSN and approved by DHHS
Behavior Support providers approved by SCDDSN/SCDHHS (Individuals and Agencies)			Scope of Service verified by DDSN and approved by DHHS
Certified Rehabilitation Counselors (Individuals and Agencies)		Certified by the Commission on Rehabilitation Counselor Certification (CRCC)	Scope of Service verified by DDSN and approved by DHHS

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	DSN Boards/contracted providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)	Department of Disabilities and Special Needs /Medicaid agency	Upon enrollment or service authorization and/or enrollment with Medicaid Agency
	Behavior support providers approved by SCDDSN/SCDHHS (Individuals and Agencies)	Department of Disabilities and Special Needs/Medicaid agency	Upon enrollment or service authorization and/or enrollment with Medicaid Agency
	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies)	Department of Disabilities and Special Needs/Medicaid agency	Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Private Vehicle Modifications

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Modifications to a privately owned vehicle to be driven by or routinely used to transport the participant. May include any equipment necessary to make the vehicle accessible to the participant. Modifications of a vehicle owned by a publicly funded agency are not permitted. Private vehicle modifications include consultation and assessment to determine the specific modifications/equipment needed, follow-up inspection after modifications are completed, training in use of equipment, repairs not covered by warranty, and replacement of parts or equipment. The approval process for private vehicle modifications is initiated based upon the needs specified in the participant's Support Plan and following confirmation of the availability of a privately owned vehicle to be driven by or routinely used to transport the participant. The approval process is the same for any private vehicle modification, regardless of ownership. Each request must receive prior approval following programmatic and fiscal review and shall be subject to the state procurement act. Programmatic approval alone may be given for emergency repair of equipment to ensure safety of the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Private Vehicle Modifications are subject to the guidelines established by DDSN and must be within the limit of $30,000 per request.

Provider Specifications

Provider Category(s) *(check one or both)***:**	■ Individual. List types:	■ Agency. List the types of agencies:
	Licensed Occupational Therapists or Physical Therapists	DSN Board/contracted providers
	Rehabilitation Engineering Technologists, Assistive Technology Practitioners, and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)	DME providers
	Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME).	Occupational Therapy or Physical Therapy Agencies

	Vendor with a retail or wholesale business license contracted to provide services	Rehabilitation Engineering Technologists, Assistive Technology Practitioners, and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)
	Technicians or professionals who are certified in the installation and repair of manufacturer's equipment	Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME).
		Vendor with a retail or wholesale business license contracted to provide services
		Technicians or professionals who are certified in the installation and repair of manufacturer's equipment

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DME Providers	Yes, Section 33-1-200 et. Seq. thru 33-1-420		Contracted with Department of Disabilities and Special Needs/Medicaid Agency
DSN Boards/contracted providers	Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103		Contracted with Department of Disabilities and Special Needs
Licensed Occupational Therapists or Physical Therapists (Individuals and Agencies)	Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103		Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Rehabilitation Engineering Technologists, Assistive Technology Practitioners, and Assistive Technology Suppliers (Individuals and Agencies)		Certified by the Rehabilitation Engineering Society of North America (RESNA)	Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Environmental Access Consultants/contractors (Individuals and Agencies)		Certified by Professional Resources in Management (PRIME)	Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Vendor with a retail or wholesale business license contracted to provide services (Individuals and Agencies)	Yes, Section 33-1-200 et. Seq. thru 33-1-420		Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Technicians or professionals who are certified in the installation and repair of manufacturer's equipment (Individuals and Agencies)	Yes, Section 33-1-200 et. Seq. thru 33-1-420		Contracted with Department of Disabilities and Special Needs/Medicaid Agency

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	DME providers	Medicaid agency	Upon enrollment or service authorization and/or Medicaid enrollment
	DSN Board/contracted providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	Occupational Therapists or Physical Therapists (Individuals and Agencies)	Medicaid agency; Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or Medicaid enrollment

	Rehabilitation Engineering Technologists, Assistive Technology Practitioners, and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA) (Individuals and Agencies)	Medicaid agency; Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or Medicaid enrollment
	Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME) (Individuals and Agencies)	Medicaid agency; Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or Medicaid enrollment
	Vendor with a retail or wholesale business license contracted to provide services (Individuals and Agencies)	Medicaid agency; Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or Medicaid enrollment
	Technicians or professionals who are certified in the installation and repair of manufacturer's equipment (Individuals and Agencies)	Medicaid agency; Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or Medicaid enrollment

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Health Education for Consumer-Directed Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Health Education for Consumer Directed Care prepares and assists capable individuals who desire to manage their own personal care or family members who desire to manage the personal care of an individual not capable of self-management. It is instruction provided by a licensed registered nurse regarding the nature of their specific medical condition and the promotion of good health, and prevention/monitoring of secondary medical conditions. The nurse will utilize the "Key to Independence Manual" from the Shepherd Center in Atlanta, Georgia or a curriculum approved by DDSN as a guide in providing education on bladder and bowel care, skin care, respiratory care, sexuality, substance abuse issues, and monitoring of health status.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	■ Individual. List types:	■ Agency. List the types of agencies:
	Registered nurses	DSN Board/contracted providers that employ/contract with registered nurses
		Provider agencies which employ/contract registered nurses
		Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF) that employ/contract with registered nurses

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DSN Board/contracted providers	Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-		Contracted with Department of Disabilities and Special Needs

	103		
Rehabilitation programs that employ/contract with registered nurses	Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103	Certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)	Contracted with Department of Disabilities and Special Needs
Registered nurses (Individuals and Agencies)	Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103		

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DSN Board/contracted providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF) that employ/contract with registered nurses	Department of Disabilities and Special Needs/Medicaid Agency	Upon enrollment or service authorization
	Registered nurses (Individuals and Agencies)	Medicaid Agency	Annually/biannually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Peer Guidance for Consumer-Directed Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
●	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Peer Guidance for Consumer Directed Care prepares and assists capable individuals who desire to manage their own personal care. It is information, advice, and encouragement provided by a trained Peer Mentor to help a person with spinal cord injury/severe physical disability in recruiting, training, and supervising primary and back-up attendant care providers. The Peer Mentor is a person with a spinal cord injury/severe physical disability who successfully lives in the community with a high degree of independence and who directs his/her personal care. The Peer Mentor serves as a role model and shares information and advice from his/her own experiences. The Peer Mentor will use the "Peer Support Curriculum" from the Shepherd Center in Atlanta, Georgia or other curriculum approved by DDSN.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	■ Individual. List types:	■ Agency. List the types of agencies:
	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)	DSN Board/contracted providers
		Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)
		Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DSN Board/contracted providers			Scope of Service verified by DDSN and approved by DHHS
Rehabilitation programs		Certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)	Scope of Service verified by DDSN and approved by DHHS

Certified Rehabilitation Counselors (Individuals and Agencies)		Certified by the Commission on Rehabilitation Counselor Certification (CRCC)	Scope of Service verified by DDSN and approved by DHHS

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	DSN Board/contracted providers	Department of Disabilities and Special Needs	Upon enrollment or service authorization
	Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)	Medicaid agency; Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or Medicaid enrollment
	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC) (Individuals and Agencies)	Medicaid agency; Department of Disabilities and Special Needs	Upon enrollment or service authorization and/or Medicaid enrollment

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Physical Therapy

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Services that are provided when physical therapy services are exhausted under the approved State plan limits. The scope and nature of these services do not differ from physical therapy furnished under the State plan. The provider qualifications specified in the State plan apply.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Physical Therapists		Physical Therapy Groups

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Physical Therapists (Individuals and Agencies)	Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.		

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Physical Therapists (Individuals and Agencies)	Medicaid Agency	Upon Enrollment

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Occupational Therapy

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Services that are provided when occupational therapy services are exhausted under the approved State plan limits. The scope and nature of these services do not differ from occupational therapy furnished under the State plan. The provider qualifications specified in the State plan apply.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Occupational Therapists		Occupational Therapy groups

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Occupational Therapist (Individuals and Agencies)	Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA.		

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Occupational Therapist (Individuals and Agencies)	Medicaid Agency	Upon Enrollment

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Speech, hearing and language services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.
Service Definition (Scope)**:**	
Services that are provided when speech, hearing and language services are exhausted under the approved State plan limits. The scope and nature of these services do not differ from speech, hearing and language services furnished under the State plan. The provider qualifications specified in the State plan apply.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Audiologists		Audiology groups
		Speech Pathologists		Speech Pathology groups
		Speech Therapists		Speech Therapy groups
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Audiologists (Individuals and Agencies)	Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA.		
Speech Pathologists (Individuals and Agencies)	Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA		
Speech Therapists (Individuals and Agencies)	Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA		

Verification of Provider	Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Qualifications	Audiologists (Individuals and Agencies)	Medicaid Agency	Upon Enrollment
	Speech Pathologists (Individuals and Agencies)	Medicaid Agency	Upon Enrollment
	Speech Therapists (Individuals and Agencies)	Medicaid Agency	Upon Enrollment

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	Prescribed Drugs, except drugs furnished to participants who are eligible for Medicare Part D benefits.

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Services that are provided when the limits of prescribed drugs under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from prescribed drug services furnished under the State plan. The provider qualifications specified in the State plan apply. An additional three (3) prescribed drugs over the State plan limit will be allowed under this waiver for individuals who are eligible for Medicaid only. Dually eligible Medicare and Medicaid individuals will not be eligible for this extended State plan service for dates of service on or after January 1, 2006.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Three additional prescription drugs above the state plan limit.

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Pharmacists		Pharmacy Providers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Pharmacists (Individuals and Agencies)	Pharmacy permit chapter 43 section 40-43-10 et.seq. SC code of laws. Equivalent in NC and GA		

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Pharmacists (Individuals and Agencies)	Medicaid Agency	Upon Enrollment

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies)*.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above*.
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
■	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Service Plan

a. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☐	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
■	Other (*specify the individuals and their qualifications):*
	Service Coordinator (qualifications specified in Appendix C-3).

b. Service Plan Development Safeguards. *Select one:*

●	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

During the planning process the participant, his/her legal guardian, caregivers, professional service providers (including physician) and others of the participant's choosing provide input. The information obtained is used by the service coordinator in order to develop the Support Plan. The participant/legal guardian will receive a copy of the Support Plan upon completion. Copies will

also be provided to other service providers of the participant's/legal guardian's choosing.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Support Plan is developed by the Service Coordinator and is based on the comprehensive assessment of the Waiver participant's, needs, personal priorities (goals) and preferences. The participant, his/her legal guardian, caregivers, professional service providers and others of the participant's choosing provide input. A Support Plan is developed prior to the delivery of a Waiver funded service and at least annually thereafter.

Service Coordinators are informed of names and definitions of Waiver services that can be funded through the Waiver. The approved Waiver document is a part of the Waiver Manual used by Service Coordinators and any Waiver Amendment is made a part of the Waiver Manual and given to Service Coordinators.

Participation in the planning process (assessment, plan development, implementation) by the participant, his/her guardian, knowledgeable professionals and others of the participant's choosing, helps to assure that the participant's needs, personal goals/priorities and preferences are recognized and addressed by the Support Plan. All needs identified during the assessment process must be addressed. The Service Coordinator will utilize information about the participant's needs, personal goals and preferences to determine how those needs will be addressed. The Support Plan will include a statement of the participant's need, indication of whether or not the need relates to a personal goal/personal priority, the specific service to meet the need, the amount, frequency, duration of the service, and the type of provider who will furnish the service.

The Support Plan will include the roles and responsibilities of the Service Coordinator and the participant and his/her guardian for each service included in the plan. The Service Coordinator will have primarily responsibility for coordinating services but must rely on the participant /guardian to choose a service provider from among those available, avail him/herself for, and honor appointments scheduled with providers when needed for initial service implementation, and cooperate with coordination efforts. The degree of coordination may vary based on the needs of the participant and his/her support network and their preferences for self-coordination.

At a minimum, Service Coordinators will provide a quarterly contact with the service provider and/or family. On a quarterly basis, there will be a review of the entire Support Plan which includes a contact with the participant/participant's family. Changes to the Support Plan will be made as needed by the Service Coordinator when the results of monitoring or when information

obtained from the participant, his/her guardian, and/or service providers indicates the need for a change to the Support Plan.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Participants' needs, including potential risks associated with their situations, are assessed during the planning process and considered during plan development. The Support Plan includes a section for a description of the plan to be implemented during an emergency or natural disaster and a description for how care will be provided in the unexpected absence of a caregiver/supporter.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants are given a list of providers of all waiver services in order to select a provider. This list includes phone numbers. Participants are encouraged to phone providers with questions, ask friends about their experiences with providers and utilize other information sources in order to select a provider.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Support Plan document and description of the planning process are approved by the Medicaid agency prior to implementation. Participant plans are available upon request. A sample of participant plans are reviewed by the operating agency and results shared with the Service Coordinator and his/her supervisor so that corrections can be made if needed. These results are also shared with DHHS. DHHS will also review a sample of plans on an annual basis.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
○	Every twelve months or more frequently when necessary
●	Other schedule (*specify*): Within 365 calendar days of the last Support Plan

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
☐	Operating agency
☐	Case manager
■	Other (*specify) Service Coordinator*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

At a minimum, Service Coordinators will provide quarterly contact with the Waiver participant and/or family. On a quarterly basis, there will be a review of the entire waiver Support Plan which includes the most recent contact with the participant's/family.

b. Monitoring Safeguards. *Select one:*

●	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

●	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
○	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
●	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The HASCI Waiver offers the participant an option to direct Attendant Care/Personal Assistance Services with employer authority. The participant or his/her Responsible Party (RP) can choose to direct the participant's care. The participant or RP must have no communication or cognitive deficits that would interfere with participant or RP direction.

Service Coordinators will provide detailed information to the Waiver participant and/or RP about participant direction as an option, including the benefits and responsibilities of the option. If the participant or RP want to pursue participant direction, additional information about the risks, responsibilities, and liabilities of the option will be shared by the Service Coordinator. Information about the role of the FMS is also provided and information concerning the hiring, management and firing of workers. Independent advocacy is available to recipients who feel the need for additional support.

Once the participant has chosen to direct his/her services, the Service Coordinator(s) will continue to monitor service delivery and the status of the participant's health and safety.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

●	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-

	employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
○	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

■	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
□	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
■	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:
	1) CRCF 2) A Private residence 3) Temporary living arrangement such as hotel/motel, shelter or camp

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	Waiver is designed to support only individuals who want to direct their services.
○	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
●	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:
	A Waiver participant or his/her Responsible Party (RP) may direct his/her own services if he/she has no communication or cognitive deficits. The Service Coordinator will assess and determine if these criteria are met.

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

At the time of the initial assessment, the Service Coordinator will introduce participant direction of Attendant Care/Personal Assistance services as an option and provide a brochure giving information about this option. The Service Coordinator will provide this information initially or at the request of

the participant. If the participant is interested, the Service Coordinator will provide more details about the benefits and responsibilities of participant direction and determine continued interest. The Service Coordinator will provide extensive information about the benefits as well as the risks, responsibilities and liabilities of participant direction. The Service Coordinator will continue to assess the participant's interest on an annual basis or more frequently if requested by the participant.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○	The State does not provide for the direction of waiver services by a representative.	
●	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:	
	■	Waiver services may be directed by a legal representative of the participant.
	■	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		A participant may choose to have waiver services directed by a representative and he/she may choose anyone (subject to DDSN or Medicaid Policy) willing to understand and assume the risks, rights and responsibilities of directing the participant's care. The chosen representative must demonstrate a strong personal commitment to the participant and knowledge of the participant's preferences, and must agree to a predetermined frequency of contact with the participant. A representative may not be paid to be a representative, and may not be paid to provide waiver services to the participant.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
UAP Attendant Care/Personal Assistance Services	■	□

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

●	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	■	Governmental entities
	⊏	Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i*.	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service entitled	

☐	as specified in Appendix C-3.
●	FMS are provided as an administrative activity. *Provide the following information:*

i. **Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:

The operating agency currently uses an FMS to provide these services to participants. This is a sole source procurement with a governmental entity.

ii. **Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment will occur to the FMS through an administrative grant from the operating agency. The payment does not come from the participant's budget.

iii. **Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

☐	Assist participant in verifying support worker citizenship status
■	Collect and process timesheets of support workers
■	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
■	Other *(specify):*

The FMS will verify the participant's verification of the worker's minimum qualifications. UAP conducts all required background checks.

Supports furnished when the participant exercises budget authority:

☐	Maintain a separate account for each participant's participant-directed budget
☐	Track and report participant funds, disbursements and the balance of participant funds
☐	Process and pay invoices for goods and services approved in the service plan
☐	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
☐	Other services and supports *(specify)*:

Additional functions/activities:

☐	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
■	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
■	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
☐	Other *(specify):*

	iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
		An annual independent audit is required to verify that expenditures are accounted for and disbursed according to General Accepted Accounting Practices.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:
■	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*
	The FMS supports are provided by a sole source contractor, which is one of the operating agency's Disabilities and Special Needs Boards. The operating agency will have a contract with the FMS to provide these supports. The supports include providing each participant with a checklist of responsibilities they have in hiring their workers, and verification of qualifications and requirements (this is accomplished jointly by UAP and the FMS). The operating agency will assess the performance of the FMS on a quarterly basis. The FMS is also required to have an independent financial audit every year.

k. Independent Advocacy *(select one)*.

●	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
	The Developmental Disabilities Council has agreed to provide this advocacy when requested. The Service Coordinator will provide their phone number and contact names to participants.
○	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service

delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The Service Coordinator will accommodate the participant by providing a list of qualified providers they can select from to maintain service delivery. The Service Coordinator and the operating agency will work together to ensure the participant's health and safety in this transition and will work to avoid any break in service delivery.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the participant or his representative are no longer able to communicate or if they experience cognitive deficits which keep them from acting in their or the participant's best interest, the Service Coordinator will transition services from participant direction to agency directed services. The authorization of agency directed services will be coordinated by the Service Coordinator. The operating agency will use written criteria in making this determination. The participant and/or representative will be informed of the opportunity and means of requesting a fair hearing, choosing an alternate provider and the plan will be revised to accommodate changes.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	100	
Year 2	120	
Year 3	140	
Year 4 (renewal only)	160	
Year 5 (renewal only)	180	

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*
■	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

■	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
■	Select staff from worker registry
■	Hire staff (common law employer)
■	Verify staff qualifications
■	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	The cost for background checks will be handled by UAP.
■	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
■	Determine staff duties consistent with the service specifications in Appendix C-3.
☐	Determine staff wages and benefits subject to applicable State limits
■	Schedule staff
■	Orient and instruct-staff in duties
■	Supervise staff
■	Evaluate staff performance
■	Verify time worked by staff and approve time sheets
■	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply*:

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's established limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential

service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

An appeal may be made on behalf of a Waiver participant by a parent or legal guardian or the Waiver participant whenever any decision adversely affects his/her eligibility status and/or receipt of services. The Waiver participant or the parents/legal guardian of the Waiver participant is informed of this decision verbally and in writing when an adverse decision is made. The formal process of review and adjudication of actions/determinations is done under the authority of Section 1-23-310 et. seq., Code of Laws, State of South Carolina, 1976, as amended, and the Department of Health and Human Services regulations Section 126-150, et.seq.

A Waiver participant or the parent/legal guardian of a Waiver participant who is dissatisfied with a level of care decision by DDSN has the right to request an appeal of the action, as well as the right to request an appeal of DDSN's decision to reduce, suspend, deny or terminate a waiver service. A Waiver participant or the parent/legal guardian of a Waiver participant who is dissatisfied with a level of care decision by SCDHHS has the right to request an appeal of the action.

A request for reconsideration of an adverse decision by DDSN must be sent in writing to the State Director at SCDDSN. A formal request for reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. In order for Waiver benefits/services to continue during the reconsideration/appeal process, the Waiver participant or the Waiver participant's parent/legal guardian's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

If the Waiver participant or the Waiver participant's parent/legal guardian continues to be dissatisfied with decision a request for appeal can be made to SCDHHS. The Waiver participant or the Waiver participant's parent/legal guardian must write a letter requesting an appeal within 30 days of the date of the official written notification issued by DDSN. If the appeal is filed within ten (10) days, services may continue pending the outcome of the hearing. If the adverse action is upheld, the Waiver participant or the Waiver participant's parent/legal guardian may be required to repay Waiver benefits received during the reconsideration/appeal process.

Information regarding the right to appeal and instructions for initiating an appeal are printed on the Notice of Suspension, Denial, Reduction and Termination Forms and the formal letter of denial from DDSN for eligibility. Also included on these forms is the information on continuation of services and possible liability if the participant elects to continue receiving services.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
●	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

●	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Department of Disabilities and Special Needs operates the Complaint/Grievance System.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Complaints are taken at the Department of Disabilities and Special Needs. A Waiver participant or the Waiver participant's parent/legal guardian are notified of their right to complain/grieve through a Participant's Rights and Responsibilities statement reviewed and signed at the initial visit during waiver entry. When a Waiver participant or the Waiver participant's parent/legal guardian elects to file a grievance or make a complaint, the Waiver participant or the Waiver participant's parent/legal guardian is informed that doing so is not a prerequisite or substitute for a Fair Hearing.

Each applicant for services or participant has the right to make complaints regarding services or treatment. Every effort will be made to resolve concerns as quickly as possible and at the most immediate staff level that can properly address the concern.

A three-step process is established to ensure a fair and impartial review of complaints. The written grievance/appeal will be made to the HASCI Division Director. The HASCI Division Director or designee shall investigate the concern. The HASCI Division Director shall issue a written decision within ten (10) working days of receipt of the written grievance/appeal. If the grievance/appeal is resolved, it shall be acknowledged in writing and documented in the consumer's record.

If the Waiver participant or the Waiver participant's parent/legal guardian is not satisfied, he/she may appeal in writing to the Associate State Director for Policy. The Associate State Director for Policy shall review the facts of the case and all supporting documents, consult with the HASCI Division, and render a written decision within ten (10) working days. If the grievance/appeal is resolved, it shall be acknowledged in writing and documented in the participant's record.

If the Waiver participant or the Waiver participant's parent/legal guardian is not satisfied with this decision, he/she may appeal in writing. All information regarding reconsiderations and appeals for the HASCI Waiver is in Appendix F-1 of this application.

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The South Carolina Child Protection Reform Act as specified in Section 20-7-480, et seq, requires reporting of abuse, neglect and exploitation to those state agencies having statutory authority to receive reports and investigate allegations of suspected abuse, neglect or exploitation. The South Carolina Omnibus Adult Protection Act as specified in S.C. Code Ann. Section 43-35-5 (2006), et seq., Section 43-35-10, requires the reporting of suspected abuse, neglect, or exploitation of a vulnerable adult, age 18 and above. These agencies include Child Protective Services and Adult Protective Services - South Carolina Department of Social Services (DSS) and local and state law enforcement agencies (The appropriate reporting agency is determined by the age of the victim, suspected perpetrator, and the location of the alleged incident). These reports can be made by phone or written form. All verbal reports shall subsequently be submitted in writing. These incidents are defined as physical abuse, emotional, mental or psychological abuse, verbal, threatened or sexual abuse, neglect, and physical and financial exploitation. Mandatory reporters have a duty to report if they have information, facts or evidence that would lead a reasonable person to believe that a child has been or is at risk for abuse, neglect or exploitation. Mandated reporters are defined as professional staff, employees, and volunteers or contract provider agencies having a legal responsibility under state law to report suspected abuse, neglect, or exploitation to state investigative agencies. Mandated reporters must make the report within 24 hours or the next business day after discovery of the abuse, neglect or exploitation.

The reporting of Critical Incidents (100-09-DD) must be followed. A critical incident is an "unusual, unfavorable occurrence that is: a) not consistent with routine operations; b) has harmful or otherwise negative effects involving people with disabilities, employees, or property; and c) occurs in a DDSN Regional Center, DSN Board facility, other service provider facility, or during the direct provision of DDSN funded services (e.g., if a child receiving service coordination services sustains a serious injury while the service coordinator is in the child's home, then it should be reported as a critical incident; however if the service coordinator is not in the home when the injury occurred then it would not be reported)". An example of a critical incident includes but is not limited to possession of firearms, weapons or explosives or consumer accidents which result in serious injury requiring hospitalization or medical treatment from injuries received.

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DSN Boards/contracted provider agencies are required to follow the SCDDSN policy specifically 534-02-DD, Procedures for Preventing and Reporting Abuse, Neglect or Exploitation of People Receiving Services from DDSN or a Contract Provider Agency and 100-09-DD, Reporting of Critical Incidents. When a mandated reporter of the agency(s) suspects any

abuse, neglect or exploitation they are required to make a report to the state agency(s) having statutory authority to receive and investigate the report.

In accordance with directives 100-09-DD, Reporting of Critical Incidents, 505-02-DD, Death or Impending Death of Person Residing in a Residential Program Sponsored by DDSN and 534-02-DD, Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contract Provider, DDSN Division of Quality Management provided training to providers in November and December 2007. In accordance with Policy Directive 567-01-DD, Pre-service Training Requirements and Orientation, DSN Board/contracted providers must provide training at least annually regarding prevention of abuse, neglect and exploitation. Competency is demonstrated with a combination of written tests and skills checks.

Waiver recipients will be provided written information about reporting abuse, neglect and exploitation. Annually, Waiver recipients will receive information about reporting abuse, neglect and exploitation. The information will be provided by Service Coordinators and will explain who is a vulnerable adult, what is abuse, and providers' phone numbers of where to report suspected abuse cases if they occur in a private home or nursing home.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

When there is reason to believe that a child has been abused, neglected, or exploited, in the home or other community setting, employees and other mandated reporters have a duty to report according to established procedures and state law. DSS is the mandated agency to investigate suspected abuse, neglect, or exploitation in these settings. DDSN/DHHS and its contract provider agencies shall be available to provide information and assistance to DSS. Procedures have been established for DDSN/DHHS to assist contract provider agencies in resolving issues with DSS regarding intake referrals and investigations. DSS will conduct a complete investigation and contact law enforcement if criminal violations are suspected. If the investigation is substantiated, notification is sent to appropriate agencies for personnel and other required actions to be taken. If the alleged perpetrator is also employed by DDSN or DHHS, a contract provider agency, or the family and abuse, neglect, or exploitation is substantiated, the employee will be terminated. When there is reason to believe that an adult has been abused, neglected or exploited in any residential program regardless of location, mandated reporters have a duty to make a report to the State Law Enforcement Department (SLED). If a suspected abuse occurs in any setting other than a home operated by or contracted for operation by DDSN, a report should be made to the County DSS (Adult Protective Services). DDSN works closely with SLED regarding critical events and/or incidents. In addition, critical incidents occurring at DDSN regional centers, DSN Board facilities, other service provider location, or while a consumer is under the supervision of staff or a contracted employee from an aforementioned provider, shall be reported to the Director, Division of Quality Management with DDSN. On a regular basis DDSN quality management staff will review critical incidents, analyze data for trends, and recommend changes in policy, practice, or training that may reduce the risk of such events occurring in the future. Statewide trend data will be provided to regional centers, DSN Boards and contracted service providers to enhance awareness activities as a prevention strategy. Each regional center, DSN Board or contracted service provider will also utilize their respective risk managers and committees to regularly review all critical incidents for trends and to determine if the recommendations made in the final written

reports were actually implemented and are in effect.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DSS Child Protective Services and local and state law enforcement are responsible for overseeing the reporting of and response to critical incidents. In addition to investigations by the State Ombudsman, DSS, and law enforcement, other agencies have jurisdiction to make inquiry into incidents of abuse, neglect, or exploitation and may conduct their own investigation. These agencies include:

SLED/Child Fatalities Review Office
The Child Fatalities Review Office of the State Law Enforcement Division will investigate all deaths involving abuse, physical and sexual trauma as well as suspicious and questionable deaths of children. The State Child Fatalities Review Office will also review the involvement that various agencies may have had with the child prior to death.

Protection and Advocacy for People with Disabilities, Inc.
Protection and Advocacy for People with Disabilities (P&A) has statutory authority to investigate abuse and neglect of people with disabilities.

In addition, the DDSN Division of Quality Management maintains information on the incidence of abuse, neglect, or exploitation, including trend analyses to identify and respond to patterns of abuse, neglect, or exploitation. All data collected is considered confidential and is used in developing abuse prevention programs. All reports of abuse, neglect or exploitation are reviewed for consistency and completeness to assure the victim is safe, and to take immediate personnel action. DDSN requires that all identified alleged perpetrators be placed on administrative leave without pay until the investigation is completed. Periodic audits of the abuse reporting system are conducted to ensure compliance with state law.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed except for Item G-2-c-ii.

a. Applicability. *Select one:*

●	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(complete only Item G-2-c-ii)*	
○	This Appendix applies. Check each that applies:	
	☐	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	☐	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete item G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

c. Safeguards Concerning the Use of Restrictive Interventions

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The operating agency (DDSN) is responsible for oversight. DDSN contracts with the service coordination provider to monitor the Support Plan which includes asking the participant and their representative their satisfaction with service delivery on an ongoing basis. This plan will be reviewed by the Service Coordinator and the operating agency prior to implementation to ensure it does not contain any restraint or seclusion interventions.

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

●	**Yes**. This Appendix applies *(complete the remaining items)*.
○	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

DDSN has policies and standards that must be followed by DSN Board provider agencies/contracted providers. DSN Board/contracted service provider staff/quality assurance and management staff are responsible for monitoring to assure policies and standards are being met.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DDSN has standards and policies that must be followed by all DSN Boards/provider agencies. DSN Boards/provider agencies including quality assurance and management staff are responsible for adherence to standards and policies. DSN Boards/provider agencies are responsible for recording medication errors/events DDSN may request and review the data collected at any time. Critical incidents must be reported to DDSN and are reviewed by DDSN staff. The outcome data is analyzed and reviewed with recommended changes or training.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

●	Waiver providers are responsible for the administration of medications to waiver

	participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Policy Directive 100-29-DD, "Medication Error/Event Reporting", Policy Directive 603-11-DD, "Monitoring Psychopharmacologic and Antiepileptic Medication for Side Effects", Policy Directive 603-13-DD, "Medication Technician Certification and Policy Directive 1000-09-DD, "Reporting of Critical Incidents" are utilized by DDSN provider agencies.

iii. Medication Error Reporting. *Select one of the following:*

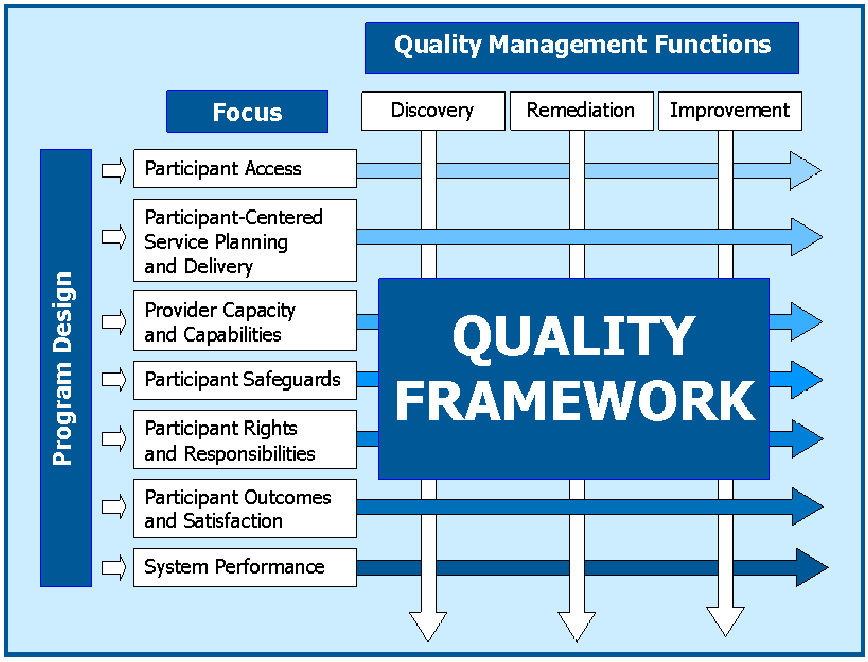
●	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	South Carolina Department of Disabilities and Special Needs. Medication errors (such as naming, compounding packaging, etc.) that are outside the control of DDSN and its network of service providers must be reported to the pharmacist in order for corrective action to occur.
	(b) Specify the types of medication errors that providers are required to *record:*
	In Policy Directive 100-29-DD medication errors include the following: wrong person given a medication, wrong medication given, wrong dosage given, wrong route of administration, wrong time, medication not given by staff (i.e. omission) and medication given without a prescriber's order. Other medication errors include: transcription and documentation errors and "red flag" events. Red flag events include the following: a person refuses medication, a "near miss" where a medication error almost occurred, unsafe circumstances and when a discarded medication is found for example on the floor, etc.
	(c) Specify the types of medication errors that providers must *report* to the State:
	Bona fide or "true" medication errors, transcription and documentation errors and "red flag" events.
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DSN Boards/contracted provider agencies/South Carolina Department of Disabilities and Special Needs.

Appendix H: Quality Management Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.



Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy**.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

DDSN has a multi-tiered quality management system that was designed using the CMS quality framework. This system is grounded in the uniform collection and analysis of reliable and valid data. The design of this system sets the stage for achieving person-centered desired outcomes along the following dimensions: level of care determination, service plan, qualified providers, health and welfare, administrative authority, and financial accountability. The quality management functions gauge the effectiveness and functionality of our design and pinpoint where attention should be devoted to secure improved outcomes. It encompasses 3 functions: discovery (collecting data and participant's experiences), remediation (taking action to remedy specific problems or trends that occur), and

continuous improvement (using data and quality information to engage in actions that lead to continuous improvement in service delivery). Data is trended and analyzed monthly and where possible compared with national data. In areas that require strengthening, the agency develops an action plan with all stakeholders and re-evaluates the effectiveness of the interventions on an annual basis.

DHHS has a comprehensive Quality Management process that has been developed and refined over the last several years based upon State initiatives and ongoing consultation and technical assistance from Thomson Medstat, the national quality improvement organization contracted by CMS. Quality assurance practices have been developed to ensure the standards defined for the program are maintained and quality services are provided to our participants.

Assurances and Requirements

Initial Level of Care Evaluations:
All people referred for Waiver services go through a formal intake process. Criteria are applied to ensure that potential Waiver participants meet the minimum requirements. A determination is made as to which type of LOC assessment, ICF/MR or NF, is most appropriate. The initial ICF/MR Level of Care assessment is conducted by the operating agency/Consumer Assessment Team. DDSN ensures ICF/MR Level of Care (LOC) determinations are accurate and appropriate.

An initial Nursing Facility/Level of Care assessment is requested through the local SCDHHS Community Long Term Care Division using a nurse consultant. The service coordinator is notified of the Level of Care determination by the nurse consultant. The nurse consultant keys the results of the LOC into the automated DHHS Case Management System (CMS). The data of all initial NF/Level of Care assessments are maintained in the CMS and can be accessed electronically as needed.

Information obtained NF/Level of Care assessment is provided to the HASCI Waiver Administrator at DHHS and the service coordinator. The outcome of the initial NF/LOC assessment is conveyed to the HASCI Waiver Coordinator at DDSN during Waiver enrollment. The State has an automated tickler system for ICF/MR LOC information.

Level of Care Re-evaluations:
Enrolled participants are re-evaluated at least annually or more frequently if warranted. The service coordinator conducts the ICF/MR and Nursing Facility Level of Care re-evaluations. The DDSN participant data system generates reports that indicate participants that are due for re-evaluations to ensure they are completed timely. Each service coordinator receives on-line feedback about the status of the re-evaluations due in the next 3 months. They are reminded monthly until completed. The service coordinator's supervisor is notified when the re-evaluation is due within one month. This system permits early identification of problems and potential problems so action can be taken quickly. The level of care process is monitored by both the state operating agency and the Medicaid agency. Both agencies have a tracking system to monitor the LOC re-evaluation process. LOC re-evaluations that have not been completed appropriately are returned to the contracted provider by the operating agency. The Medicaid agency keeps a copy of the LOC re-evaluation in the participant's file. Trend data is evaluated quarterly to determine statewide issues that may require a change in policy or procedure. Technical assistance is provided to those providers who need help with the timeliness and completeness of their referrals for LOC determination. Action is taken to address inappropriate level of care determinations.

LOC Oversight:
Monitoring of initial, re-evaluation, and adverse ICF/MR level of care determinations are performed by a DHHS contracted independent quality improvement organization (QIO). A representative sample of records is selected and the case record documentation is reviewed by the QIO for level of care validation. The QIO verifies supporting documentation and monitors compliance with Medicaid criteria. The QIO

produces detailed, summary reports on a monthly basis to DHHS reporting their findings and any recommendations for policy clarification. Upon receipt of this information, DHHS presents the findings to DDSN for discussion and necessary action.

Service Plan/Plan of Care:
DDSN ensures that the Support Plan addresses all participants' needs and personal goals, whether by waiver services or other means. The Support Plan is updated as changes in the waiver participant's situation occur. Services are delivered in accordance with the Support Plan. DDSN monitors Support Plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of the Plan.

DDSN's participant data support system, which includes the Support Plan also contains the assessment data, therefore the assessment and Support Plan documents are linked. This means that needs identified through the assessment process must be addressed through the POC document or the system will not allow the service coordinator to proceed.

DDSN contracts with a QIO to conduct face-to-face interviews and complete annual participant/family surveys to supplement the quality review process. Data are analyzed and shared within the organization, service providers and the Medicaid agency to improve services and satisfaction of participants.

DDSN uses the QIO to conduct annual and follow-up quality assurance reviews of participants using the Support Plan as the main source of information. The review indicators are lined up with the CMS quality framework to ensure its comprehensiveness. This includes ensuring the provider type, amount, frequency, and duration criteria are met.

DDSN reviews a 5% sample of Plans for Waiver participants that will be due in 90 days through the internal Plan review process. The Plan is reviewed according to the Plan Review Checklist. The Plan Review Checklist is returned to the service coordination supervisor at the local DSN Board provider/contracted provider. The service coordination supervisor is responsible for follow up with the service coordinator regarding any deficient indicators on the Review Checklist and verifies all changes/corrections are made to the participant's Plan.

Service Plan/Plan of Care Oversight: DHHS has dedicated quality assurance (QA) staff to monitor POC, through focus reviews of assessed needs of the participant, LOC assessment, health and welfare, and freedom of choice issues.

Qualified Providers:
DDSN verifies, on a periodic basis, that providers meet required certification standards and adhere to other state standards. All providers are reviewed annually, and a sample of their employees' personnel files is reviewed to ensure minimum qualifications are met.

Qualified Providers Oversight:
DHHS monitors provider records to ensure proper service authorizations are on file, services are billed to Medicaid as authorized, and personnel continue to meet waiver standards and qualifications. The findings are summarized and discussed with DDSN and appropriate action is taken.

Health and Welfare:
DDSN assures participants' health, safety and welfare on a regular basis. It identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation. By South Carolina Code, the state investigative

agency for children under 18 is the Department of Social Services. They receive and investigate reports of abuse and neglect. DDSN simultaneously receives reports of alleged abuse to ensure the first response is protecting the child, and then to determine if trends are noted. In all cases, the alleged perpetrator is not allowed to provide services until the investigation is complete. If abuse is substantiated, the employee is terminated. The state investigative agency for participants' age 18 and above who reside in any residential program operated or contracted for operation by DDSN is the South Carolina Law Enforcement Division (SLED). For any setting other than a home or contracted for operation by DDSN, the county DSS is responsible for the investigation. DDSN works closely with state agencies regarding investigative findings and to assure a participant's health, safety and welfare.

Health and Welfare Oversight:
Health and welfare concerns are monitored by the DHHS QA staff through case record reviews. The QA process includes receiving incident, abuse, neglect, and mortality reports that are used to trend data and perform follow-up focus reviews. Health and welfare issues are also investigated by The SC Department of Social Services' Adult & Child Protective Services, The SC Department of Mental Health, and the Long Term Care Division of the Ombudsman's Office. In addition, participants may utilize The SC Department of Health and Environmental Control's hotline to report incidents of abuse, neglect, and unsafe living conditions.

Administrative Authority:
DHHS engages in routine ongoing oversight of the waiver program. Responsibilities include but are not limited to: enforcing the terms and conditions of the Memorandum of Agreement, improving and clarifying policies and procedures to ensure system performance, and waiver operations.

DHHS' QA process also includes verifying claims and records for consistency with dates and services billed, and also monitoring and investigating reports of abuse, neglect, and mortality as necessary. Case reviews are conducted at least quarterly to ensure waiver compliance. DHHS shares findings with the operating agency in order for them to be aware of their performance, as well as to present any corrective action(s) that need to be taken.

Financial Accountability:
DDSN conducts financial oversight through a review of claims to ensure that they are coded and paid for in accordance with the reimbursement methodology specified in the waiver. Claims must meet all applicable criteria to be submitted to Medicaid Management Information System (MMIS) for payment at which time the billing code determines the rate of reimbursement.

Financial Accountability Oversight:
Ongoing monitoring of finances is conducted by DHHS Fiscal, Audits, and Program Integrity staff.
DHHS also utilizes the QA process to monitor the paid claims data and participant utilization reports.
Cost reports are developed to ensure that funds are being applied and used properly by analyzing financial records maintained by the state, sub-state entities and providers. All findings are used to determine needed improvements as well as corrective actions.

Roles and Responsibilities/Review of Findings/Report of Findings:

DDSN and DHHS continue to develop and improve the quality management (QM) systems. DDSN is evaluating the validity and reliability of its QM system through a systems change grant from CMS. Preliminary results indicate a strong statistically significant relationship between DDSN's QA processes and participant outcomes. DDSN and DHHS meet regularly to discuss the results of all data collected and analyzed related to waiver participants' outcomes and experiences with the waiver. Areas requiring

improvement are discussed and an action plan is implemented. This leads to continuous quality improvement.

Quality Management Strategy:

Evaluating the six assurances through a QA process allows DHHS to utilize the findings in various ways to identify and address areas of major concern, to identify issues for policy change, corrective action, training needs, and provider compliance. The combined information allows the QA entity to perform focus reviews and develop trending reports to assure waiver eligible participants are served fairly and equitably based on Medicaid policy and procedure.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State employs several methods to ensure the integrity of payments made for Waiver services in different departments within the agency. Following are descriptions of the methods employed:

The State has a Memorandum of Agreement with the operating agency, DDSN, to assure provider qualifications for the provision of HASCI Waiver services and Service Coordination. DDSN maintains a quality review process utilizing their quality assurance contractor to ensure provider qualifications are valid and appropriate. The review consists of three components: staffing review, administrative review and participant review. The staffing review samples staff members at different levels to ensure they meet all initial training and certification requirements, tuberculin skin test requirements, ongoing training requirements and all other specified requirements. The administrative review determines that all agency administrative requirements (liability insurance, list of officers, written by-laws, emergency back-up plans, etc.) have been met. The participant review verifies that all requirements relating to the actual conduct of service have been met.

The Division of Program Integrity at DHHS responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects and analyzes provider data in order to identify billing exceptions and deviations. In this capacity, Program Integrity may audit payments to service providers. Issues that involve fraudulent billing by providers are turned over to the Medicaid Fraud Control Unit in the South Carolina Attorney General's Office. In addition, the Division of Audits reviews DHHS contracts with external entities in order to ensure that contract terms are met and only allowable costs are charged.

Each DSN Board is required to perform a yearly audit of their financial position. These yearly audits are performed by independent CPA firms to determine if provider agencies are upholding general accepted accounting practices and are maintaining a sound financial position.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Bureau of Reimbursement Methodology and Policy, with assistance from DDSN, is responsible for the development of Waiver service payment rates. The Bureau of Reimbursement Methodology operates under the direction of the South Carolina Department of Health and Human Services. The Medicaid agency allows the public to offer comments on waiver rate changes and rate setting methodology either through Medical Care Advisory Committee meetings, public hearings, or through meetings with association representatives.

Waiver service rates were established based upon the projected costs of the service to be provided. Projected costs used in the determination of the Waiver rates would include salaries, fringe benefits, travel, training, and applicable overhead costs (which is less than 10%). Billable hours were determined in order to adjust for time spent on leave, training, travel, and administration. Both DDSN and the Bureau of Reimbursement Methodology perform financial reviews on an as needed basis to ensure that funding provided by the South Carolina General Assembly was appropriately expended by providers of these services.

The Service Coordination service rates provided to Waiver participants were based upon the projected costs of the service to be provided and adjusted for patient caseload. Projected costs used in the determination of the Waiver rates would include salaries, fringe benefits, travel, training, and the applicable overhead costs (which is less than 10%). Billable hours were determined in order to adjust for time spent on leave, training, travel, and administration. The reasonableness of the Service Coordination rate developed was determined by comparing the rate against private provider Service Coordination/Case Management rates for children/adults similar to those enrolling in the Waiver.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers maintain the option of billing directly to the Medicaid agency or they may voluntarily reassign their right to direct payments to the Department of Disabilities and Special Needs. Providers billing Medicaid directly may bill either by use of a CMS 1500 form or by the State's electronic billing system.

c. Certifying Public Expenditures *(select one)*:

- ● **Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):

	■	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
		(a) – The South Carolina Department of Disabilities and Special Needs (SCDDSN). (b) – SCDDSN files annual cost reports that report the total costs incurred for both their institutional services (i.e. ICF/MRs) and all Waiver services providers. (c) – The SCDDSN received $4.5 million in state appropriations for these services in SFY 2006/2007. The contract between SCDHHS and SCDDSN applicable to these services will require the following contract language: "SCDDSN agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable, and necessary cost for the provision of services to be provided to Medicaid recipients under the contract prior to submitting claims under the contract." Additionally, the Internal Audit Division within the SCDHHS has included in its' audit plan planned audits of State Agency Medicaid contracts.
	□	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
○		**No**. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Claims for Waiver services are submitted to MMIS through either the use of a CMS 1500 form or through the State's electronic billing system. Providers of Waiver services are given a service authorization, which reflects the service identified on the Support Plan. This authorization is produced by the Service Coordinator and contains the frequency, date and type of service authorized along with a unique authorization number. Once the claim is submitted to MMIS, payment is made to the provider only if the participant was Medicaid eligible on the date of service and there is an indication in MMIS that the participant is enrolled in the Waiver program. This is the case for all claims.

The DHHS Division of Program Integrity conducts post-payment reviews. These reviews sample claims and determine if services have been billed as authorized.

The DDSN internal audit division periodically conducts audits of DDSN's billing system to ensure billing is appropriate for the service provided.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

●	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

■	The Medicaid agency makes payments directly to providers of waiver services.
☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
■	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
	A financial management services (FMS) entity is used to make payments for in-home services delivered by individuals rather than agencies. These individuals document service delivery and provide data to the financial management service. This information is transferred to DDSN, which in turn bills MMIS for services rendered. The FMS cuts checks biweekly and transfers funds to workers by direct deposit. Financial audits are performed periodically.
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

○	**No**. The State does not make supplemental or enhanced payments for waiver services.
●	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.
	SCDDSN will be reimbursed retrospectively for its total allowable Medicaid costs incurred of providing services under this Waiver. Therefore, the supplemental payment will equate to a cost settlement that will be determined upon the completion of the SCDHHS review of the annual cost report submitted by the SCDDSN.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

●	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
	SCDDSN will receive payment for waiver services and will provide the following waiver services: UAP Attendant Care services to include any DSN Board billed Waiver services and Service Coordination.
○	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

○	The amount paid to public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
●	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

	SCDDSN will submit annual cost reports that reflect the total costs incurred by SCDDSN and/or its local Boards of the services provided under this Waiver. The SCDHHS will desk review the cost report and determine the average unit cost of the services provided under this Waiver based upon costs and units of the total population served (ie., both Medicaid and non-Medicaid recipients). The actual cost rate will then be compared against the interim rate paid to determine an overpayment or underpayment. If an overpayment occurs, the SCDHHS will recoup the federal portion of the overpayment from the SCDDSN and return it to CMS via the quarterly expenditure report.

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

●	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

●	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
	The Department of Disabilities and Special Needs
○	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

●	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

	(a) DDSN operates as an organized health care delivery system (OHCDS). This system of care is comprised of DDSN and the local DSN County Boards and together they form an OHCDS. The OHCDS establishes contracts with other qualified providers to furnish home and community based services to people served in this waiver. (b) Providers of Waiver services may direct bill their services to DHHS. (c) At a minimum, Waiver participants are given a choice of providers, regardless of their affiliate with the OHCDS, annually or more frequent if requested or warranted (d) DDSN will assure that providers that furnish Waiver services under contract with the OHCDS meet applicable provider qualifications through the state's procurement process. (e) DDSN assures that contracts with providers meet applicable requirements via an annual quality assurance review of the provider, as well as periodic record reviews. (f) DDSN requires its local DSN County Boards to perform annual financial audits.
○	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
●	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

☐	**Appropriation of State Tax Revenues to the State Medicaid agency**
■	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
	The South Carolina Department of Disabilities and Special Needs (SCDDSN) received state appropriations to provide services under this Waiver. A portion of these funds will be transferred to the South Carolina Department of Health and Human Services (SCDHHS) via an Interdepartmental Transfer (IDT) for payments that will be made directly to private providers enrolled with the SCDHHS. For services provided by SCDDSN, these funds will be directly expended by SCDDSN as CPE.
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
■	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
■	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
●	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

This Head and Spinal Cord Injury waiver has only one service, residential habilitation, in which room and board could be included in the service. Continual monitoring and training is provided to assure that room and board costs are excluded. Through the annual audits, financial testing of residential cost is performed by independent CPA firms to assure that room and board costs are excluded from Medicaid payment.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
●	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

●	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

●	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:			**NF and ICF/MR**				
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$28,190	$9,935	$38,126	$43,894	$7,452	$51,346	$13,220
2	$28,393	$10,233	$38,626	$45,211	$7,676	$52,887	$14,260
3	$29,327	$10,540	$39,867	$46,567	$7,906	$54,473	$14,606
4	$30,092	$10,856	$40,948	$47,964	$8,143	$56,107	$15,159
5	$30,425	$11,182	$41,607	$49,403	$8,388	$57,791	$16,184

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: NF	Level of Care: ICF/MR
Year 1	788	772	16
Year 2	842	825	17
Year 3	892	874	18
Year 4	945	926	19
Year 5	998	978	20

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

Year 1 – 11.09 months; 333 days
Year 2 – 11.63 months; 334 days
Year 3 – 11.65 months; 335 days
Year 4 – 11.67 months; 336 days
Year 5 – 11.69 months; 337 days

This derivation is based on current 372 data with an inflation factor of 5% built in to account for increases in enrollments over the last two years of the preceding waiver.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates are based on projected utilization of services. The projected utilizations are based on current industry practices for each service level included in the waiver. The costs per services were determined by surveying current provider of services.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The derivation of the figures originate with the CMS 372 Report for Waiver #0284.01.R1 for the year ending 6/30/2007 with an inflation factor of 5% for year one and 3% for year two through year five.

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

HASCI WAIVER YEAR: Year 1 – NF and ICF/MR					
HASCI Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
1. RESIDENTIAL HABILITATION	Per Day	47	348	$200.00	$3,271,200
2. SUPPORTED EMPLOYMENT SERVICES	Per Hour	16	46	$20.43	$15,036
3. DAY HABILITATION	Per Day	16	244	$31.00	$121,024
4. PREVOCATIONAL SERVICES	Per Day	16	244	$31.00	$121,024
5.RESPITE CARE					
Non-Institution Based	Per Hour	158	383	$8.30	$502,266
Non-Institution Based	Per Day	158	35	$66.40	$367,192
Institution – NF/Hospital Based	Per Day	8	35	$130.00	$36,400
Institution – ICF/MR Based	Per Day	8	35	$250.00	$70,000
CRCF Respite	Per Day	8	23	$50.00	$9,200
6. MEDICAL SUPPLIES, EQUIPMENT AND ASSISTIVE TECHNOLOGY	Per Item	433	25	$100.00	$1,082,500
7. PRIVATE VEHICLE MODIFICATIONS	Per Item	39	1	$18,000.00	$702,000
8. ENVIRONMENTAL MODIFICATIONS	Per Item	47	1	$12,000.00	$564,000
9. PERSONAL EMERGENCY RESPONSE SYSTEMS					
Initial Installation	Per Item	55	1	$36.00	$1,980
Recurring Maintenance	Per Item	165	12	$36.00	$71,280
10. PRESCRIBED DRUGS	Per Item	134	35	$35.00	$164,150
11. MEDICAID WAIVER NURSING					
Register Nurse	Per Hour	39	429	$33.00	$552,123
Licensed Practical Nurse	Per Hour	39	742	$25.00	$723,450
12. OCCUPATIONAL THERAPY	Per Hour	8	70	$60.00	$33,600
13. PHYSICAL THERAPY	Per Hour	8	46	$60.00	$22,080
14. PSYCHOLOGICAL SERVICES					
Counseling Services	Per Hour	16	46	$60.00	$44,160
Drug Alcohol Counseling	Per Hour	16	46	$40.00	$29,440
Psychological Consultation	Per Hour	16	46	$50.00	$12,160
15. BEHAVIORAL SUPPORT SERVICES	Per Hour	16	46	$60.00	$44,160
16. SPEECH, HEARING AND LANGUAGE SERVICES					
Licensed Speech Therapist	Per Hour	8	46	$40.00	$14,720
Licensed Audiologist	Per Hour	8	46	$60.00	$22,080
Licensed SLP	Per Hour	8	46	$40.00	$14,720
17. ATTENDANT CARE/PERSONAL ASSISTANCE SERVICES					
Agency/Board Billed	Per Hour	315	1856	$16.80	$9,821,952
Self Direct	Per Hour	142	1856	$14.30	$3,768,794
18. HEALTH EDUCATION FOR CONSUMER- DIRECTED CARE	Per Unit	24	12	$20.00	$5,760
19. PEER GUIDANCE FOR CONSUMER- DIRECTED CARE	Per Unit	24	12	$20.00	$5,760
GRAND TOTAL:					$22,214,211
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					788
FACTOR D (Divide grand total by number of participants)					$28,191
AVERAGE LENGTH OF STAY ON THE WAIVER					333

HASCI WAIVER YEAR: Year 2 – NF and ICF/MR					
HASCI Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
1. RESIDENTIAL HABILITATION	Per Day	51	349	$200.00	$3,559,800
2. SUPPORTED EMPLOYMENT SERVICES	Per Hour	17	47	$20.43	$16,324
3. DAY HABILITATION	Per Day	17	244	$31.00	$128,588
4. PREVOCATIONAL SERVICES	Per Day	17	244	$31.00	$128,588
5.RESPITE CARE					
Non-Institution Based	Per Hour	168	384	$8.30	$535,450
Non-Institution Based	Per Day	168	35	$66.40	$390,432
Institution – NF/Hospital Based	Per Day	8	35	$130.00	$36,400
Institution – ICF/MR Based	Per Day	8	35	$250.00	$70,000
CRCF Respite	Per Day	8	23	$50.00	$9,200
6. MEDICAL SUPPLIES, EQUIPMENT AND ASSISTIVE TECHNOLOGY	Per Item	463	25	$100.00	$1,157,500
7. PRIVATE VEHICLE MODIFICATIONS	Per Item	42	1	$18,000.00	$756,000
8. ENVIRONMENTAL MODIFICATIONS	Per Item	51	1	$12,000.00	$612,000
9. PERSONAL EMERGENCY RESPONSE SYSTEMS					
Initial Installation	Per Item	59	1	$36.00	$2,124
Recurring Maintenance	Per Item	177	12	$36.00	$76,464
10. PRESCRIBED DRUGS	Per Item	143	35	$35.00	$175,175
11. MEDICAID WAIVER NURSING					
Register Nurse	Per Hour	42	430	$33.00	$595,980
Licensed Practical Nurse	Per Hour	42	744	$25.00	$781,200
12. OCCUPATIONAL THERAPY	Per Hour	8	70	$60.00	$33,600
13. PHYSICAL THERAPY	Per Hour	8	47	$60.00	$22,560
14. PSYCHOLOGICAL SERVICES					
Counseling Services	Per Hour	17	47	$60.00	$47,940
Drug Alcohol Counseling	Per Hour	17	47	$40.00	$31,960
Psychological Consultation	Per Hour	17	1	$760.00	$12,920
15. BEHAVIORAL SUPPORT SERVICES	Per Hour	27	47	$60.00	$76,140
16. SPEECH, HEARING AND LANGUAGE SERVICES					
Licensed Speech Therapist	Per Hour	8	47	$60.00	$15,040
Licensed Audiologist	Per Hour	8	47	$40.00	$22,560
Licensed SLP	Per Hour	8	47	$60.00	$15,040
17. ATTENDANT CARE/PERSONAL ASSISTANCE SERVICES					
Agency/Board Billed	Per Hour	337	1861	$16.80	$10,536,238
Self Direct	Per Hour	152	1861	$14.30	$4,045,070
18. HEALTH EDUCATION FOR CONSUMER-DIRECTED CARE	Per Unit	35	12	$20.00	$8,400
19. PEER GUIDANCE FOR CONSUMER DIRECTED-CARE	Per Unit	35	12	$20.00	$8,400
GRAND TOTAL:					$23,907,091
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					842
FACTOR D (Divide grand total by number of participants)					$28,393
AVERAGE LENGTH OF STAY ON THE WAIVER					334

HASCI WAIVER YEAR: Year 3 – NF and ICF/MR					
HASCI Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
1. RESIDENTIAL HABILITATION	Per Day	54	350	$206.00	$3,893,400
2. SUPPORTED EMPLOYMENT SERVICES	Per Hour	18	47	$21.04	$17,800
3. DAY HABILITATION	Per Day	18	245	$36.05	$158,981
4. PREVOCATIONAL SERVICES	Per Day	18	245	$36.05	$158,981
5.RESPITE CARE					
Non-Institution Based	Per Hour	178	384	$8.55	$584,410
Non-Institution Based	Per Day	178	35	$68.39	$426,070
Institution – NF/Hospital Based	Per Day	9	35	$133.90	$42,179
Institution – ICF/MR Based	Per Day	9	35	$257.50	$81,113
CRCF Respite	Per Day	9	23	$51.50	$10,661
6. MEDICAL SUPPLIES, EQUIPMENT AND ASSISTIVE TECHNOLOGY	Per Item	491	25	$100.00	$1,227,500
7. PRIVATE VEHICLE MODIFICATIONS	Per Item	45	1	$18,000.00	$810,000
8. ENVIRONMENTAL MODIFICATIONS	Per Item	54	1	$12,000.00	$648,000
9. PERSONAL EMERGENCY RESPONSE SYSTEMS					
Initial Installation	Per Item	62	1	$37.08	$2,299
Recurring Maintenance	Per Item	187	12	$37.08	$83,208
10. PRESCRIBED DRUGS	Per Item	152	35	$37.10	$197,372
11. MEDICAID WAIVER NURSING					
Register Nurse	Per Hour	45	431	$33.99	$659,236
Licensed Practical Nurse	Per Hour	45	746	$25.75	$864,428
12. OCCUPATIONAL THERAPY	Per Hour	9	70	$61.80	$38,934
13. PHYSICAL THERAPY	Per Hour	9	47	$61.80	$26,141
14. PSYCHOLOGICAL SERVICES					
Counseling Services	Per Hour	18	47	$61.80	$52,283
Drug Alcohol Counseling	Per Hour	18	47	$41.20	$34,855
Psychological Consultation	Per Hour	18	1	$782.80	$14,090
15. BEHAVIORAL SUPPORT SERVICES	Per Hour	38	47	$61.80	$110,375
16. SPEECH, HEARING AND LANGUAGE SERVICES					
Licensed Speech Therapist	Per Hour	9	47	$41.20	$17,428
Licensed Audiologist	Per Hour	9	47	$61.80	$26,141
Licensed SLP	Per Hour	9	47	$41.20	$17,428
17. ATTENDANT CARE/PERSONAL ASSISTANCE SERVICES					
Agency/Board Billed	Per Hour	357	1864	$17.30	$11,512,250
Self Direct	Per Hour	161	1864	$14.73	$4,420,532
18. HEALTH EDUCATION FOR CONSUMER-DIRECTED CARE	Per Unit	47	12	$20.60	$11,618
19. PEER GUIDANCE FOR CONSUMER-DIRECTED CARE	Per Unit	47	12	$20.60	$11,618
GRAND TOTAL:					$26,159,328
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					892
FACTOR D (Divide grand total by number of participants)					$29,327
AVERAGE LENGTH OF STAY ON THE WAIVER					335

HASCI WAIVER YEAR: Year 4 – NF and ICF/MR					
HASCI Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
1. RESIDENTIAL HABILITATION	Per Day	57	350	$212.18	$4,232,991
2. SUPPORTED EMPLOYMENT SERVICES	Per Hour	19	47	$21.67	$19,351
3. DAY HABILITATION	Per Day	19	245	$37.13	$172,840
4. PREVOCATIONAL SERVICES	Per Day	19	245	$37.13	$172,840
5.RESPITE CARE					
Non-Institution Based	Per Hour	189	385	$8.81	$641,060
Non-Institution Based	Per Day	189	35	$70.44	$465,961
Institution – NF/Hospital Based	Per Day	9	35	$137.92	$43,445
Institution – ICF/MR Based	Per Day	9	35	$265.23	$83,547
CRCF Respite	Per Day	9	23	$53.05	$10,981
6. MEDICAL SUPPLIES, EQUIPMENT AND ASSISTIVE TECHNOLOGY	Per Item	520	25	$100.00	$1,300,000
7. PRIVATE VEHICLE MODIFICATIONS	Per Item	47	1	$18,000.00	$846,000
8. ENVIRONMENTAL MODIFICATIONS	Per Item	57	1	$12,000.00	$684,000
9. PERSONAL EMERGENCY RESPONSE SYSTEMS					
Initial Installation	Per Item	66	1	$38.19	$2,521
Recurring Maintenance	Per Item	198	12	$38.19	$90,739
10. PRESCRIBED DRUGS	Per Item	161	35	$39.33	$221,625
11. MEDICAID WAIVER NURSING					
Register Nurse	Per Hour	47	432	$35.01	$710,843
Licensed Practical Nurse	Per Hour	47	747	$26.52	$931,091
12. OCCUPATIONAL THERAPY	Per Hour	9	70	$63.65	$40,100
13. PHYSICAL THERAPY	Per Hour	9	47	$63.65	$26,924
14. PSYCHOLOGICAL SERVICES					
Counseling Services	Per Hour	19	47	$63.65	$56,839
Drug Alcohol Counseling	Per Hour	19	47	$42.44	$37,899
Psychological Consultation	Per Hour	19	1	$806.28	$15,319
15. BEHAVIORAL SUPPORT SERVICES	Per Hour	49	47	$63.65	$146,586
16. SPEECH, HEARING AND LANGUAGE SERVICES					
Licensed Speech Therapist	Per Hour	9	47	$42.44	$17,952
Licensed Audiologist	Per Hour	9	47	$63.65	$26,924
Licensed SLP	Per Hour	9	47	$42.44	$17,952
17. ATTENDANT CARE/PERSONAL ASSISTANCE SERVICES					
Agency/Board Billed	Per Hour	378	1867	$17.82	$12,576,037
Self Direct	Per Hour	170	1867	$15.17	$4,814,806
18. HEALTH EDUCATION FOR CONSUMER-DIRECTED CARE	Per Unit	58	12	21.22	$14,769
19. PEER GUIDANCE FOR CONSUMER-DIRECTED CARE	Per Unit	58	12	21.22	$14,769
GRAND TOTAL:					$28,436,712
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					945
FACTOR D (Divide grand total by number of participants)					$30,092
AVERAGE LENGTH OF STAY ON THE WAIVER					336

HASCI WAIVER YEAR: Year 5 – NF and ICF/MR					
HASCI Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
1. RESIDENTIAL HABILITATION	Per Day	59	351	$218.55	$4,525,952
2. SUPPORTED EMPLOYMENT SERVICES	Per Hour	20	47	$22.32	$20,981
3. DAY HABILITATION	Per Day	20	245	$38.25	$187,425
4. PREVOCATIONAL SERVICES	Per Day	20	245	$38.25	$187,425
5.RESPITE CARE					
Non-Institution Based	Per Hour	196	386	$9.07	$686,200
Non-Institution Based	Per Day	196	35	$72.56	$497,762
Institution – NF/Hospital Based	Per Day	10	35	$142.05	$49,718
Institution – ICF/MR Based	Per Day	10	35	$273.18	$95,613
CRCF Respite	Per Day	10	23	$54.64	$12,567
6. MEDICAL SUPPLIES, EQUIPMENT AND ASSISTIVE TECHNOLOGY	Per Item	538	25	$100.00	$1,345,000
7. PRIVATE VEHICLE MODIFICATIONS	Per Item	49	1	$18,000.00	$882 ,000
8. ENVIRONMENTAL MODIFICATIONS	Per Item	59	1	$12,000.00	$708,000
9. PERSONAL EMERGENCY RESPONSE SYSTEMS					
Initial Installation	Per Item	68	1	$39.34	$2,675
Recurring Maintenance	Per Item	205	12	$39.34	$96,776
10. PRESCRIBED DRUGS	Per Item	166	35	$41.69	$242,219
11. MEDICAID WAIVER NURSING					
Register Nurse	Per Hour	49	433	$36.06	$765,085
Licensed Practical Nurse	Per Hour	49	748	$27.32	$1,001,333
12. OCCUPATIONAL THERAPY	Per Hour	10	70	$65.56	$45,892
13. PHYSICAL THERAPY	Per Hour	10	47	$65.56	$30,813
14. PSYCHOLOGICAL SERVICES					
Counseling Services	Per Hour	20	47	$65.56	$61,626
Drug Alcohol Counseling	Per Hour	20	47	$43.71	$41,087
Psychological Consultation	Per Hour	20	1	$830.47	$16,609
15. BEHAVIORAL SUPPORT SERVICES	Per Hour	60	47	$32.78	$184,879
16. SPEECH, HEARING AND LANGUAGE SERVICES					
Licensed Speech Therapist	Per Hour	10	47	$43.71	$20,544
Licensed Audiologist	Per Hour	10	47	$65.56	$30,813
Licensed SLP	Per Hour	10	47	$43.71	$20,544
17. ATTENDANT CARE/PERSONAL ASSISTANCE SERVICES					
Agency/Board Billed	Per Hour	391	1870	$18.36	$13,424,281
Self Direct	Per Hour	176	1870	$15.63	$5,144,146
18. HEALTH EDUCATION FOR CONSUMER-DIRECTED CARE	Per Unit	69	12	$21.85	$18,092
19. PEER GUIDANCE FOR CONSUMER-DIRECTED CARE	Per Unit	69	12	$21.85	$18,092
GRAND TOTAL:					$30,364,149
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					978
FACTOR D (Divide grand total by number of participants)					$30,425
AVERAGE LENGTH OF STAY ON THE WAIVER					337